Supreme Court, U.S.
FILED
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No.

In The

SUPREME COURT OF THE UNITED STATES

STEPHEN SIMON,
Petitioner

v.

VALUE BEHAVIORAL HEALTH INC. ET AL,
Respondent(s)

On Petition For a Writ of Certiorari to
To The United States Court of Appeals
For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

STEPHEN SIMON,
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65pp

QUESTION(S) PRESENTED FOR REVIEW

I. Whether an assignment of benefits and/or assignment of cause of action to a healthcare provider from a "participant" of a Employee Retirement Income Security Act ("ERISA") health and welfare plan and who [provider] subsequently reassigns to a "creditor" with UCC holding who [creditor] subsequently brings a legal action individually and as assignee of assignor [provider] against an ERISA plan for denial of ERISA benefits pursuant to 29 U.S.C. § 1132 alleging either vested interest, colorable claim, derivative standing and/or beneficiary status is sufficient to proceed with such claims for relief and with standing to sue in the United States District Court?

II. Whether the defined term "beneficiary" pursuant to 29 U.S.C. § 1002(8) wherein it refers to the term "designate" and since according to Black's Law Dictionary is synonymous with Black's Law defined term "appoint" that in turn is synonymous or interchangeable with Black's Law defined term "assign" and, as such, does an assignee with assignment of benefits and assignment of cause of action so designated by a "participant" of an ERISA health and welfare employee benefit plan and based upon the plain natural language reading of the Black's Law defined terms "beneficiary", "appoint", and "assign" constitute congressional intent that such similarly situated "assignees" are equivalent to "beneficiaries" and, as such, are enumerated parties pursuant to 29 U.S.C. § 1002(8) with standing to sue in the United States District Court?

III. Whether the defined term "beneficiary" pursuant to 29

U.S.C. § 1002(8) wherein it states, "...or by the terms of the employee benefit plan...or may become entitled to a benefit thereunder" and when any given ERISA health and welfare employee benefit plan does not prohibit or otherwise allow for assignability or to the extent assignment(s) are allowed or silent under the terms thereunder, then can such an assignee with a valid assignment(s) of either assignment of benefits and/or an assignment of cause of action proceed as a "beneficiary" based on the plain natural reading of the statute with standing to sue and is consistent with congressional intent?

IV. Whether a holding by a U.S. District Court or Appellate Court in dismissing or affirming a dismissal of a complaint for lack of standing to sue for denial of benefits of a ERISA health and welfare plan when the Petitioner is an ultimate assignee of the "participant" of the said ERISA plan with valid assignments of accounts receivable and assignment of cause of action and who has plead a vested interest, colorable claim, derivative standing, and/or beneficiary status arising out of creditor status with UCC filings and/or purports to be a beneficiary by assignment, constitutes a violation of the United States Constitution including but not limited to Article III by depriving due process to the Courts for redress including preemption of state law or common law unlawful taking of private property without due process to the Courts for redress and considering ERISA preemption of state law and/or common law causes of action that collectively constitute the unlawful taking of private property without due process?

V. Whether the federal courts have sufficiently established a broad enough "judicial exception" by only allowing

healthcare providers standing to sue against an ERISA employee health and welfare plan while depriving other qualified citizens who have vested rights and interests individually and/or by assignment to seek redress for their respective damages and losses in the federal courts after statutory preemption of state law causes?

VI. Whether the federal courts establishment of judicial exception of "healthcare providers" granting derivative standing to sue under present federal common law is limited to healthcare providers who actually provided the services as opposed to healthcare providers who obtained assignments from those providers and in contrast to attorneys who can openly trade and share commissions amongst themselves without any restrictions and/or prohibitions?

VII. Was the Petitioner in the Simon vs. Value matter improperly precluded from obtaining service of process of hundreds of employee benefit plans when service of process was properly effectuated upon "administrators and/or trustees" of those respective ERISA plans pursuant to 29 U.S.C. § 1132(d)(1) and after Judge Gary L. Taylor of the United States District Court, Central District of California missed interpreted the plain natural reading of that statute and/or refused or failed to consider the contractual terms of each of the respective 600 employee benefit plans at issue and was subsequently affirmed without comment by the U.S. Ninth Circuit of Appeals resulting in substantial losses and damages due to the running of the statute of limitations and pending adjudication from the Appellate Court?

VIII. Was the Petitioner in the Simon vs. Value matter improperly prejudiced by the orders of the Honorable Judge Gary L. Taylor that resulted in severe prejudice to this pro se litigant that who should have been entitled under federal common law and case law to "liberal construction of pleadings" but instead was discriminated against and chastised by the Court for bringing the action against so many Respondents and who subsequently all of the estimated 1,600 Respondents except for one in what apparently was based upon his own personal case management issues?

IX. Whether the United States District Court retains jurisdiction of an ERISA cause of action against a health and welfare employee benefit plan irregardless of whether the Plaintiff was deemed to be the "real party in interest" pursuant to Fed.R.Civ.P. 17(a) and otherwise deprive all parties of equitable redress including the actual real party in interest while subjecting all of the Petitioner parties in interest to res judicata and/or collateral estoppel doctrine?

X. Did the U.S. Ninth Circuit Court of Appeals have appellate jurisdiction since the lower court did not adjudicate the FEHBA claims in any of the lower cour's orders and because there was no final order in the lower court?

XI. Whether or not the holding of the U.S. Ninth Circuit Court of Appeals should stand in light of allegations generally characterized as discrimination, impropriety(s), suppression of information/evidence, obstruction of the administration of justice and other acts and omissions that are generally characterized as prejudicial and bias and/or contrary and/or

inconsistent with the Federal Rules of Appellate Procedure, U.S. Ninth Circuit Court Rules, Federal Statutes, Congressional Acts, and Codes of Judicial Conduct subject to the Judicial Council's affirmation in part or whole pursuant to proceedings presently pending pursuant to 28 U.S.C. § 372(c)(1) as amended by § 402(a) of the Judicial Discipline and Removal Reform Act of 1990?

XII. Did the U.S. Ninth Circuit Court of Appeals panel overlook or ignore conflicting case law within the Ninth Circuit that would have otherwise given good cause to reverse and/or remand to the lower court including but not limited to Davidowitz vs. Delta Dental Plan Inc., 946 F.2d 1476 (9th Cir. 1991) and other Supreme Court holdings including but not limited to Fentron Industries et al vs. The National Shopmen Pension Fund et al, 674 F.2d 1300, 1982 U.S. App. LEXIS 19924 and Haynes vs. Kerner et al, 404 U.S. 519, 92 S.Ct. 594, 30 L.Ed.2d 653 (1972)?

LIST OF PARTIES

All parties **do not** appear in the caption of the case on the cover page. A list of all parties to the proceeding in the court whose judgment is the subject of this petition is as follows: Guardian Life Insurance Company of America; Value Health Inc.; Robert E. Patricelli; American PsychManagement, Inc.; Preferred HealthCare, Ltd.; Health Management Strategies International, Inc.; The Prudential Insurance Company of America; HealthCare Systems, Inc.; Health Risk Management; Health Insurance Association of America; John Hancock Mutual Life Insurance Co.; CostCare, Inc.; John Hancock Mutual Life Insurance Company Employee Benefit Plan; Blue Cross & Blue

Shield Association; Blue Cross & Blue Shield of Illinois, Inc.; Blue Cross/Blue Shield of Iowa, Inc.; Blue Cross/Blue Shield of Kansas, Inc.; Blue Cross/Blue Shield of Massachusetts, Inc.; Blue Cross/Blue Shield of Michigan, Inc.; Empire Blue Cross/Blue Shield; New York Life Insurance Company; Blue Cross/Blue Shield of Texas, Inc.; Administrator and/or Trustee on behalf of Paune Extrusions Company Employee Benefit Plan; Blue Cross/Blue Shield of Virginia, Inc.; Administrator and/or Trustee on Behalf of Commonwealth University Employee Benefit Plan; Metro Inc. Information Services Employee Benefit Plan, Department of Motor Vehicles of the Commonwealth of Virginia Employee Benefit Plan, Linsky Plan Farm, Inc. Employee Benefit Plan, Memorial Hospital, Inc. Employee Benefit Plan; Virginia Polytechnic Institute and State University Employee Benefit Plan, Campbell County Transport Employee Benefit Plan, State of Virginia Employee Benefit Plan, Hodgerman's Company Employee Benefit Plan; American General Life & Accident Insurance Co., Administrator and/or Trustee on behalf of American General Life & Accident Insurance Co. Employee Benefit Plan; Benefit Trust Life, Administrator and/or Trustee on Behalf of Lagrange Country Club, Inc. Employee Benefit Plan, Wood Tech, Inc. Employee Benefit Plan; Blue Cross of Alaska; Blue Cross of Washington; Specialty Medical Clinic Employee Benefit Plan, Bell Atlantic Corporation; C & P Telephone; Tuthill Corporation; FKW, Inc.; Blue Cross/Blue Shield of Minnesota; Blue Cross/Blue Shield of Maine; Bankers Life and Casualty Company; National Association of Health Underwriters; City of Lewiston School Department; ReliaStar Life Insurance Company; PPG Industries Inc.; Ventura Insurance Administrators, Inc.; Ventura County Foundation for Medical Care, Inc.; A & P Grocery Store, Inc., A & P Grocery Store, Inc. Employee Benefit Plan; Crawford Insurance Company; Security Benefit Trust Fund, Roofers Local 149 Security Benefit Trust Fund; Roofers Local 149 Employee

Benefit Plan; ITT Hartford Group, Inc.; ITT Hartford Group, Inc., as Administrator and/or Trustee; General American Life Insurance Company; Genelco; Pan-American Life Insurance Company; National Insurance Services; David Koppe; William McGuire, M.D.; MetraHealth Care Management Corporation; United HealthCare Corporation; United HealthCare Corporation Employee Benefit Plan; United HealthCare Services, Inc.; United Behavioral Systems, Inc.; Operating Engineers Local 37 Health and Welfare Fund; CappCare, Inc.; Michael Henry; Health International, Inc.; Health International Corporation; Stanislaus Foundation for Medical Care; Executive Risk; Benefit Panel Services; Great-West Life Assurance Company; Rocky Mountain Medical Services dba Blue Cross and Blue Shield of Colorado; Carpenters Health and Welfare Trust for Southern California, Carpenters; Pension Trust for Southern California; Carpenters Southern California Administrative Corporation; Millwrights Local Union No. 1607; Carpenters Local Union No. 1506; Chicago District Council of Carpenters Welfare Fund; Chicago District Council of Carpenters Pension Fund; Retail Clerks-Employers Benefit Plan of Northern California and Valley Clerks Trust Fund; CT Corporation, CSC The United States Corporation; Blue Cross/Blue Shield of California; Metropolitan Life Insurance Company, Administrators and/or Trustee on Behalf of: Chemical Bank Inc. Employee Benefit Plan; New York State Frewway Authority Employee Benefit Plan, New York State Department Civic Employee Benefit Division, Sun Chemical Corporation Employee Benefit Plan, Dunn & Bradstreet Employee Benfeit Plan, Rockwell International, Inc. Employee Benefit Plan, ZEP Manufacturing Company Employee Benefit Plan, National Services Industreis, Inc. Employee Benefit Plan, F.W. Woolworth Company Employee Benefit Plan, Nordstrom's Inc. Employee Benefit Plan; Town of New Paltz Employee Benefit Plan; Trustees of the American Engineers Council Insurance Trust Fund; Felker Benefit Services; Pepsico

Inc. Employee Benefit Plan; Ukiah Unified School District Employee Benefit Plan; Louisiana-Pacific, Inc. Employee Benefit Plan, General Electric Company Employee Benefit Plan; City of Culver Employee Benefit Plan; California Conservation Corp. Employee Benefit Plan; Allcare Plan; Transport International Tools Inc. Employee Benefit Plan; Wood Company Employee Benefit Plan; Montgomery Ward Inc. Employee Benefit Plan; R.H. Macy's Inc. Employee Benefit Plan; McDonough Capperton, Inc. Employee Benefit Plan; MetraHealth; Unified Behavioral Systems, Inc.; National Association of Underwriters; Southwestern Bell Employee Benefit Plan; Universal City Studios Inc.; Universal Studios Employee Benefit Plan; Mutual of Omaha; HealthCare Compare Corporation; Health Risk Management Inc.; Benefit Administrators Inc.; Care America, Inc.; Uniformed Service Benefit Plan; U.S. Postal Service; Yuma Proving Ground; U.S. Army; U.S. Marine Corps; U.S. Navy; U.S. Air Force; U.S. Coast Guard; United States of America; First Health Inc.; Blue Cross/Blue Shield of Alabama; Service Master Inc. Employee Benefit Plan; Gary Methodist Hospital Inc.; Gary Methodist Hospital, Inc. Employee Benefit Plan; Lewiston School; Maine State Correctional Institution Employee Benefit Plan; Blue Cross/Blue Shield of Oregon, Inc., Administrator and/or Trustee on behalf of Safeway Stores, Inc. Employee Benefit Plan; Painters Local 10 Employee Benefit Plan; John Q. Hammonds Hotels, Inc. Employee Benefit Plan; Adventist Health System of Loma Linda, Administrator and/or Trustee on behalf of Loma Linda School of Medicine Health Assistance and Medical Personnel Services Plan; United Chambers Insured Plans; American Community Mutual Insurance Co.; American Trust Administrators; Automotive Industries Welfare Fund Medical Plan; Brown Group Insurance Co., Administrators and/or Trustee on behalf of Brown Group Insurance Co. HealthCare Plan; Bankers Life & Casualty Company, Administrator and/or on behalf of City of Chicago

Employee Benefit Plan; The Vollrath Company, Inc.; The Vollrath Company, Inc. Employee Benefit Plan; Chubb Life America; Comparative Ins Serv; McDonnell Douglas Corp/Douglas Aircraft Company; Screen Actors Guild-Producers Pension Plan; Swim Chem Products Inc.; Great Lakes Chemical Bank Inc; BL Network Inc. Employee Benefit Plan; Group Resources Inc.; Harcourt Brace Jovanovich, Inc.; Health Economics Corporation; City/County of San Francisco; Insurnational Insurance Administrators, Inc.; Intermountain Administrators, Inc.; Laborers Health & Welfare Trust for Southern California; McDowell Agency, Inc.; Mutual Assurance; San Francisco Print Industry Welfare Fund; Newspaper & Periodical Driver's & Helper's Union Local 921-Publisher's Welfare Trust; Pavers and Road Builders District Council Welfare Fund; Jack Wickware; IBEW-NECA Southwestern Health and Benefit Fund; Wal-Mart Inc.; Wal-Mart Inc. Associates Group Health Plan; State Farm Mutual Automobile Insurance Company; Group Health Incorporated; Federated Mutual Insurance Company; European Car Parts, Inc. Employee Benefit Plan; F.W. Woolworth Co.; F.W. Woolworth Co. Employee Benefit Plan; Paula Assurance Co.; Pan American Underwriters Inc.; Gallagher Bassett Services Inc.; Employees Benefit Administration and Management Corporation; Milk & Ice Cream Employees Welfare Plan; Blue Cross/Blue Shield of Delaware; Blue Cross Blue Shield of Indiana; Blue Cross Blue Shield of Kentucky; Blue Cross Blue Shield of New Jersey; Blue Cross Blue Shield of Connecticut; United Assurance Company; NALC Health Benefit Plan; Indian Child Protective Services; Northern Indiana State Developmental Center; Columbia HCA HealthCare Corporation; United Assurance Company of America.

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Fentron Industries et al vs. The National Shopmen Pension Fund et al, 674 F.2d 1300, 1982 U.S. App. LEXIS 19924 .....
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Black's Law Dictionary (Sixth Edition) .....
Article III of the Constitution of the United States .....

PETITION FOR WRIT OF CERTIORARI

The Petitioner respectfully requests that a writ of certiorari be issued to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit is reported at *Stephen Simon vs. Value Behavioral Health Inc. et al.*, 208 F.3d 1072 (9th Cir. 2000).

The opinion of the United States District Court for the Central District of California is reported at *Stephen Simon vs. Value Behavioral Health Inc. et al.* 955 F.Supp. 973 (C.D. Cal. 1997).

STATEMENT OF JURISDICTION

The date on which the United States Ninth Circuit Court of Appeals decided my case was on June 7th, 2000.

A timely petition for rehearing was denied by the United States Ninth Circuit Court of Appeals on the following date: June 7th, 2000, and a copy of the order denying rehearing appears at Appendix C.

The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS

15 U.S.C. § 12 (RICO)
18 U.S.C. § 1961
18 U.S.C. § 1961(3)
18 U.S.C. § 1961(4)
18 U.S.C. § 1962
26 U.S.C. § 665
28 U.S.C. § 372(c)(1)
28 U.S.C. § 402(a)
28 U.S.C. § 1291
28 U.S.C. § 1331
28 U.S.C. § 1332
28 U.S.C. § 2107(b)
29 U.S.C. § 1001(b)
29 U.S.C. § 1002(1)
29 U.S.C. § 1002(2)(A)
29 U.S.C. § 1002(8)
29 U.S.C. § 1002(16)(A)
29 U.S.C. § 1056(d)
29 U.S.C. § 1056(d)(1)
29 U.S.C. § 1132(a)
29 U.S.C. § 1132(a)(1)
29 U.S.C. § 1132(a)(1)(B)
29 U.S.C. § 1132(d)(1)
29 U.S.C. § 1132(e)(2)
Fed.R.Civ.P. Rule 4(a)
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Fed.R.Civ.P. Rule 21
Fed.R.Civ.P. Rule 25
Fed.R.Civ.P., Rule 56
Article III of the Constitution of the United States of America
Fed.R.App.P. 35(b)
Fed.R.App.P. 35(c)
RICO § 2(b)

STATEMENT OF THE CASE

Petitioner asserts that the record will clearly show that the U.S.D.C.J. unreasonably and unfairly ruled against the Plaintiff at almost every juncture.

The U.S.D.C.J.'s holding that dismissed the ERISA cause of action based on Plaintiff's standing was akin to *"cutting out the heart"* of what was the *"hub of the wheel"* of this lawsuit that gave rise to the other causes of action.

The U.S.D.C.J. improperly dismissed all of the Defendants (except one) based on *"case management"* and notwithstanding Judge Taylor's acknowledgment that the Defendants did, in fact, have one thing in common, *"common denial of this kind of claim"*.

The Honorable Judge Taylor repeatedly expressed his frustration over the magnitude of the number of Defendants and their counsel along with the prospect of confronting the practicalities of this complex litigation and chose to take the path of least resistance by dismantling Plaintiff's lawsuit.

In the last hearing Judge Taylor specifically addressed the members of the Ninth Circuit as if the record on appeal would not be sufficient to reveal whether or not justice had actually been served and stated,

> *"For the benefit of my good friends at the Court of Appeals...First of all this is not a situation in which a pro per is not being afforded an opportunity to amend. We have done that over and over and over with what I think is a very careful and thoughtful explanation by the Court as to what he needs to...the plaintiff thinks that for these insurers to deny payments of these claims is illegal. And what the Court has held is that it's not illegal and what they are doing is what they normally do as insurers and they're not required by law to cover this kind of a claim..."*

Upon reflection of this case, there are many remaining unanswered questions as to how and why the Honorable Judge Gary Taylor could have reasonably come to the conclusions that led to his rulings including but not limited to:

(a) why from the beginning of the proceedings was Judge Taylor so impatient with the Petitioner including unreasonably refusing to allow adequate time to serve over 1,600 Respondents and instead actually shortened the time?

(b) why did Judge Taylor quash Petitioner's service of process upon hundreds of ERISA plans without apparent regard to the ERISA statute or proper review of the ERISA plan documents and despite Petitioner's opposition(s)?

(c) why did Judge Taylor refuse to allow Petitioner to discover crucial evidence that would have enabled Petitioner

to supplement his pleadings and provide factual and convincing documentation and instead ruled that the pleadings were insufficient?

(d) why did Judge Taylor refuse to certify Petitioner's motion for interlocutory appeal despite Judge Taylor's invitation to the Ninth Circuit Court for intervention when he stated *"without further authority from the Ninth Circuit"*?

(e) why did Judge Taylor continue to search for reasons outside of Petitioners' pleadings as to those conspiracy allegations involving hundreds of ERISA plans, employers, insurance companies, and affiliated entities instead of accepting as true Plaintiff's pleadings within the four corners of the complaint(s)?

(f) why was Judge Taylor convinced that the professional services rendered by Petitioners' Assignors were somehow different from standard professional mental health services exemplified by the U.S.D.C.J.'s statement *"But the reason, the basis, the unusual nature of the care that form the basis for non-payment was what? What was the nature? – ..."* and despite Plaintiff's response to same, *"...Your Honor, the care that was provided was traditional care except for the philosophy was holistic. All of the providers are licensed psychiatrists, psychologists, marriage and family counselors."*

(g) why and how did Judge Taylor reasonably conclude that, *"...they're [insurers] not required by law to cover this kind of claim..."*? especially in light of Petitioner's pleadings including alleged fraudulent fee fixing and wholesale denial(s) of claims involving over 638 separate ERISA claims?

(h) why did Judge Taylor rule against Plaintiff's alleged conspiracy(s) amongst all of the Respondents despite his own

acknowledgment that there was at the very least a *"common denial of this kind of claim"*?

(i) why did Judge Taylor dismiss all of the estimated 1,600 Respondents (except one) sua sponte based on *"case management"* and refused to consider Petitioner's motion(s) to rejoin Respondent(s) when the U.S.D.C.J. surely must have known that these dismissals would be fatal to Petitioner's lawsuit based on the statute of limitations?

(j) why did Judge Taylor refuse to accept Petitioner's pleadings as true on the face of it and instead appeared confused over many of the allegations and issues of fact while emanating a profound sense of disbelief along with expressing recurring statements of ambivalence over the magnitude of the proceedings?; and

(k) why did Judge Taylor diminish Petitioner's pro se status instead of granting the due and proper latitude normally extended to pro se litigants including liberal construction of pleadings?

In conclusion, I believe that the Supreme Court Justices will determine that justice has not been served as they attempt to answer these and other questions. The Petitioner also trusts that the Supreme Court Justices will grant further *"authority"* so that Petitioner's ERISA standing to sue can be established as a matter of consistent with other related Court of Appeals case law and in accordance with Judge Taylor's proviso *"without further authority from the Ninth Circuit"*.

The Petitioner also remains confident that given a fair and reasonable opportunity to replead all of the causes of action and to supplement same with evidence obtained through discovery that he can and will proceed on to the

merits of the case.

Finally, this is definitely a case that was prematurely and unjustly aborted at the pleading stage. It should also be fairly clear that justice cannot be served when a District Court suppresses vital evidence while simultaneously misapplying statutory provisions and Federal Rules of Civil Procedure including the basic premise of acceptance of Plaintiff's pleadings as true on the face of it along with the total disregard of Petitioner's fraudulent conspiracy allegations and other properly plead allegations.

This is also a case where the District Court has not extended liberal construction to pro se pleadings or other similar applications. Instead, the District Court was unreasonably strict with the Petitioner even in the face of overwhelming opposition in terms of the total numbers of Respondents and their respective counsel along with the vast resources that they have collectively assembled. Therefore, I firmly believe that the Supreme Court will agree that justice, fairness, and reasonableness have not triumphed in this case.

Petitioner respectfully reminds the Supreme Court Justices that this case goes far beyond justice for the Respondent. In fact, should the Supreme Court affirm the Court of Appeals ruling on Petitioner's ERISA standing to sue, that would significantly narrow the scope of those prior holdings of the Ninth Circuit Court of Appeals consistent with expanded rulings on ERISA standing to sue and, as such, would establish an alarming and conflicting precedent. In addition, an adverse ruling at this juncture would encourage those Respondents to continue their unlawful activities that have significantly restrained and adversely impacted the entire mental health profession along with tens of thousands of patients who are participants and beneficiaries of ERISA

plans while simultaneously enabling those co-conspiring Respondents to escape justice.

The Petitioner greatly appreciates the opportunity that our United States judicial system affords litigants to appeal unjust, unfair, and adverse rulings and is now hopeful that this Supreme Court Justices of the United States Supreme Court will find favor in Petitioner's appeal and in the preservation of justice for one and for all.

The Petitioner looks forward to the appointed time and place to personally appear for the purpose of oral presentation before the Supreme Court Justices of the United States Supreme Court in God speed.

REASONS FOR GRANTING THE PETITION

Petitioner is aware of the chances of the United States Supreme Court granting a Petition for Writ of Certiorari that rarely occurs in cases of such imperative public importance. In *Simon vs. Value Behavioral Health*, the U.S. District Court's denial of Plaintiffs' standing to sue and the U.S. Ninth Circuit affirmation is symptomatic of yet another greater problem that exists in the United States of America and what is increasingly becoming the general public's perception that insurance companies and their ERISA Plan clients are not only beyond the reach of the law by and through the judicial interpretation's of standing to sue and access to due process for protection of their respective rights and interests, but also the increasing public outrage against these insurance companies and related entities for their willful and wanton disregard for the law and

what appears to be widespread judicial protectionism. (See USA Today Cartoon caricature 1999 attached hereto as Appendix D). It is high time that the United States Supreme Court sent a clear and resounding message to the lower court's that the citizens must have access to the Courts to redress the wrongs of these insurance companies and ERISA entities and to demonstrate that these entities are not above and beyond the law or "favorite sons" of the judiciary and privileged members of the Bar Association and that they must be held accountable for their acts, omissions, and widespread failure to make good on their contractual obligations and fiduciary responsibilities. The time is at hand for the United States Supreme Court to set the record straight as to fairness, equity, and justice for all.

CONCLUSION

Petitioner respectfully requests that the United States Supreme Court first consider the fact that this Lawsuit and subsequent appeal out of necessity has been brought in good faith. The Petitioner has also been diligent in his compliance with the F.R.C.P., F.R.A.P., Circuit Rules, and the Courts' orders, notwithstanding the fact that Petitioner has made his appearances In Propria Persona.

The Petitioner has alleged in the Lawsuit that he, as an individual and the ultimate assignee of assignors and, as such, has standing to bring those causes of action including the ERISA claims. However, the Honorable Gary L. Taylor first determined that the ERISA cause of action should not proceed "without further authority from the Ninth Circuit" and then subsequently dismissed all of the estimated 1,600 Defendants and finally the single remaining Defendant with prejudice in

the Third Amended Complaint.

In sum, the Supreme Court has been summoned to determine whether or not Petitioners' collective arguments of law and contentions of facts, as set forth herein, are sufficient to vacate, reverse, and/or remand for further proceedings.

Secondly, the Petitioner has suffered significant personal financial losses and damages to his twenty (20) year career in the mental health field. Whereas, this Lawsuit constitutes the Petitioner's only available legal remedy for equitable and injunctive relief and, as such, Petitioner prays for justice and an opportunity to present his evidence before the United States Supreme Court as promised in the Constitution of the United States of America.

The Supreme Court Justices have been assigned the authority to oversee this judicial process and, as such, "stands in the shoes" of the proverbial watchman and as "shepherds" over the flocks.

The petition for a writ of certiorari should be granted.

Respectfully submitted,

STEPHEN SIMON, Petitioner
In Propria Persona

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Dated: November 9, 2000

Appendix A

208 F.3d 1073
2000-1 Trade Casese P 72.822, RICO Bus.Disp.Guide 9856, 24 Employee Benefits Cas. 1208,
00 Cal. Daily Op. Serv. 2120, 2000 Daily Journal D.A.R. 2903
(Cite as: 208 F.3d. 1073)

United States Court of Appeals,
Ninth Circuit

Stephen SIMON, an individual and as assignee of assignors, Plaintiff-Appellant,

v.

VALUE BEHAVIORAL HEALTH INC., Guardian Life Insurance Co. of America; Value Health, Inc.; Robert E. Patricelli, Ltd.; America Psychmanagement, Inc; Preferred Healthcare, Ltd.; Health Management Strategies International Inc; The Prudential Insurance Company; HealthCare Systems, Inc.; Health Risk Management, Health Insurance Association of America; John Hancock Mutual Life Insurance Co.; John Alden Life Insurance Company; Costcare, Inc; John Hancock Mutual Life Insurance Company Employee Benefit Plan; Blue Cross & Blue Shield Association; Blue Cross & Blue Shield of Illinois, Inc.; Blue Cross/Blue Shield of Iowa, Inc.; Blue Cross/Blue Shield of Kansas, Inc.; Blue Cross/Blue Shield of Massachusetts, Inc.; Blue Cross/Blue Shield of Michigan, Inc.; Empire Blue Cross/Blue Shield; New York Life Insurance Company; Blue Cross/Blue Shield of Texas, Inc., Administrator and/or Trustee on Behalf of Paune Extrusions Company Employee Benefit Plan; Blue Cross/Blue Shield of Virginia, Inc. Administrator and/or Trustee on Behalf of Commonwealth University Employee Benefit Plan, Metro Inc. Information Services Employee Benefit Plan, Department of Motor Vehicles of the Commonwealth of Virginia Employee Benefit Plan, Linsky Plant Farm, Inc. Employee Benefit Plan, Memorial Hospital, Inc., Employee Benefit Plan, Virginia

Appendix A

Polytechnic Institute and State University Employee Benefit Plan, Campbell Country Transport Employee Benefit Plan, State of Virginia Employee Benefit Plan, Hodgerman's Company Employee Benefit Plan, American General Life & Accident Insurance Co., Administrator and/or Trustee on Behalf of American General Life & Accident Insurance Co. Employee Benefit Plan; Benefit Trust Life, Administrator and/or Trustee on Behalf of Lagrange County Club, Inc. Employee Benefit Plan, Wood Tech, Inc. Employee Benefit Plan; Blue Cross of Alaska; Blue Cross of Washington; Speciality Medical Clinic Employee Benefit Plan, Bell Atlantic Corporation; C & P Telephone; Tuthill Corporation; FKW, Inc.; Blue Cross/Blue Shield of Minnesota; Blue Cross/Blue Shield of Maine; Bankers Life and Casualty Company; National Association of Health Underwriters; City of Lewiston School Department; Reliastar Life Insurance Company; PPG Industries, Inc; Ventura Insurance Administrators, Inc.; Ventura County Foundation For Medical Care, Inc.; A & P Grocery Store, Inc.; A & P Grocery Store, Inc. Employee Benefit Plan; Crawford Insurance Company; Security Benefit Trust Fund, Roofers Local 149 Security Benefit Trust Fund; Roofers Local 149 Employee Benefit Plan; ITT Hartford Group Inc., ITT Hartford Group, Inc., As Administrator and/or Trustee; General American Life Insurance Company; Genelco; Pan-America Life Insurance Company; National Insurance Services; David Koppe; William McGuire M.D.; Metrahealth Care Management Corporation; United Healthcare Corporation; United Healthcare Corporation Employee Benefit Plan; United Healthcare Services , Inc.; United Behavioral Systems, Inc.; Operating Engineers Local 37 Health and Welfare Fund; Cappcare, Inc.; Michael Henry; Health International, Inc.; erroneously served and sued as Health International Corp.; Stanislaus Foundation for Medical Care; Executive Risk; Benefit Panel Services; Great-West Life Assurance Company; Rocky Mountain Medical Services, DBA Blue Cross and Blue

Shield of Colorado; Carpenters Health and Welfare Trust for Southern California; Carpenters Pension Trust for Southern California; Carpenters Southern California Administrative Corporation; Millwrights Local Union No. 1607; Carpenters Local Union No. 1506; Chicago District Council of Carpenters Welfare Fund; Chicago District; Council of Carpenters Pension Fund; Retail Clerks-Employers Benefit Plans of Northern California and Valley Clerks Trust Fund; CT Corporation, CSC The United States Corporation; Blue Cross/Blue Shield of California; Metropolitan Life Insurance Company, Administrators and/or Trustee on Behalf of: Sears, Roebuck & Co. Group Medical Plan, Chemical Bank Inc. Employee Benefit Plan, New York State Freeway Authority Employee Benefit Plan, New York State Department Civic Employee Benefit Division, Tenneco/J.I. Case Co. Employee Benefit Plan, Sun Chemical Corporation Employee Benefit Plan, Dunn & Bradstreet Employee Benefit Plan, Rockwell International, Inc. Employee Benefit Plan, ZEP Manufacturing Company Employee Benefit Plan, National Services Industries, Inc. Employee Benefit Plan, F.W. Woolworth Company Employee Benefit Plan, Nordstrom's Inc. Employee Benefit Plan, Town of New Paltz Employee Benefit Plan, Trustees of the American Engineers Council Insurance Trust Fund, Felker Benefit Services, Pepsico, Inc. Employee Benefit Plan, Ukiah Unified School District Employee Benefit Plan, Louisiana-Pacific, Inc. Employee Benefit Plan, General Electric Company Employee Benefit Plan, Proctor & Gamble Corporation Employee Benefit Plan, City of Culver Employee Benefit Plan, California Conservation Corp. Employee Benefit Plan, Allcare Plan, Transport International Tools, Inc. Employee Benefit Plan, Wood Company Employee Benefit Plan, Montgomery Ward Inc. Employee Benefit Plan, R.H. Macy's, Inc. Employee Benefit Plan, McDonough Capperton, Inc. Employee Benefit Plan, Toys R Us Inc. Employee Benefit Plan, J.I. Case Power & Equipment, Inc. Employee Benefit Plan; MetraHealth, William

W. McGuire, M.D.; David Koppe; Unified Behavioral Systems, Inc.; National Association of Life Unerwriters; Southwestern Bell Employee Benefit Plan; Universal City Studios, Inc., Universal Studios Employee Benefit Plan; Mutual of Omaha; Healthcare Compare Corporation; Health Risk Management, Inc.; Benefit Administrators, Inc.; Care America, Inc.; Uniformed Service Benefit Plan, Inc.; U.S. Postal Service; Yuma Proving Ground; U.S. Army; U.S. Marine Corps; U.S. Navy; U.S. Air Force; U.S. Coast Guard; United States of America; First Health, Inc.; Great West Life Assurance Company; Blue Cross/Blue Shield of Alabama; Service Master, Inc. Employee Benefit Plan; Gary Methodist Hospital, Inc., Gary Methodist Hospital, Inc. Employee Benefit Plan; Lewiston School; Maine Sate Correctional Institution Employee Benefit Plan; Blue Cross/Blue Shield of Oregon, Inc., Administrator and/or Trustee on Behalf of: Safeway Stores, Inc. Employee Benefit Plan, Painters Local 10 Employee Benefit Plan, John Q. Hammonds Hotels, Inc. Employee Benefit Plan; Adventist Health System of Loma Linda, Administrator and/or Trustee on Behalf of Loma Linda School of Medicine Health Assistance and Medical Personnel Services Plan; Loma Linda School of Medicine Health Assistance and Medical Personnel Services Plan; United Chambers Insured Plans; American General Life & Accident Insurance Co., Administrator and/or Trustee on Behalf of American General Life & Accident Insurance Co. Employee Benefit Plan; American Community Mutual Insurance Co.; American Trust Administrators; Automotive Industries Welfare Fund Medical Plan, Brown Group Insurance Co., Administrators and/or Trustee on Behalf of Brown Group Insurance Co. Healthcare Plan; Bankers Life & Casualty Company, Administrator and/or Trustee on Behalf of City of Chicago Employee Benefit Plan; The Vollrath Company, Inc., The Vollrath Company, Inc. Employee Benefit Plan; Chubb Life America; Comparitive Ins. Serv.; McDonnell Douglas Corp/Douglas Aircraft Company; Screen Actors

Guild-Producers Pension Plan; Swim Chem Products, Inc., Great Lakes Chemical, Inc.; BL Network, Inc. Employee Benefit Plan; Group Resources, Inc.; Harcourt Brace Jovanovich, Inc.; Health Economics Corporation; City/County of San Francisoo; Insurnational Insurance Administrators, Inc.; Insurnational, Inc.; Intermountain Administrators, Inc.; Laborers Health & Welfare Trust for Southern California; McDowell Agency, Inc.; Mutual Assurance; San Francisco Print Industry Welfare Fund, and Newspaper & Periodical Driver's & Helper's Union Local 921-Publisher's Welfare Trust; Pavers and Road Builders District Council Welfare Fund; Jack Wickware; IBEW-NECA Southwestern Health and Benefit Fund; Wal-Mart, Inc.; Wal-Mart, Inc. Associates Group Health Plan; State Farm Mutual Automobile Insurance Company; Group Health Incorporated; Federated Mutual Insurance Company; European Care Parts, Inc.; Employee Benefit Plan; F.W. Woolworth Company Employee Benefit Plan; F.W. Woolworth Co.; Paula Assurance Co; Pan American Underwriters, Inc; Gallagher Bassett Services, Inc.; Employee Benefits Administration and Management Corporation; Milk & Ice Cream Employee Welfare Plan; Blue Cross Blue Shield of Delaware; Blue Cross Blue Shield of Indiana; Blue Cross Blue Shield of Kentucky; Blue Cross Blue Shield of New Jersey; Blue Cross Blue Shield of Connecticut; United Insurance Company of America; NALC Health Benefit Plan; Indiana Child Protective Services; Northern Indiana State Developmental Center; Columbia HCA Healthcare Corporation; Defendants-Appellants. No. 98-55905

Submitted Feb. 11, 2000 [FN 1]

FN1. The panel unanimously finds this case suitable for decision without oral argument. See Fed.R.App.P. 34(a)(2).

Filed March 17, 2000

Appendix A

Assignee, to whom employee health plan beneficiaries' claims were reassigned by health care providers, commenced action against health plans and health insurance industry defendants, alleging Employee Retirement Income Security Act (ERISA), antitrust, and Racketeer Influenced and Corrupt Organizations Act (RICO) violations. The United States District Court for the Central District of California, Gary L. Taylor, J., 955 F. Supp. 93, dismissed complaint for failure to state a claim. Plaintiff appealed. The Court of Appeals, Wiggins, Circuit Judge, held that: (1) plaintiff lacked derivative standing to bring ERISA enforcement action; (2) plaintiff failed to allege direct injury from alleged antitrust violation; (3) plaintiff failed to allege direct injury or enterprise as required for his RICO claims; and (4) district court properly denied plaintiff leave to amend.

Affirmed.

West Headnotes

[1] Federal Courts ⇨776
170BK776
Court of Appeals reviews de novo district court's dismissal of claims for failure to state claim. Fed.Rules Civ.Proc. Rule 12(b)(6), 28 U.S.C.A.

[2] Federal Courts ⇨776
170BK776

District Court's interpretation of Employee Retirement Income Security Act (ERISA) was a question of law that Court of Appeals reviewed de novo. Employee Retirement Income Security Act of 1974. § 2 et seq., 29 U.S.C.A. § 1001 et seq.

[3] Pensions ⇨139
296k139

Assignee of employee health plan beneficiaries' benefit claims lacked derivative standing to bring Employee Income Retirement Security
Act (ERISA) enforcement action, event though claims were assigned to him by health care providers that would have had derivative standing; granting derivative standing to health care providers furthered purposes of ERISA by simplifying billing structure as between provider, patient, and benefit plan, while granting derivative standing to third parties with no relationship to beneficiary would be tantamount to transforming health benefit claims into tradable commodities and would not further any ERISA purpose. Employee Retirement Income Security Act of 1974, § 502(a)(1)(B), 29 U.S.C.A. § 1132(a)(1)(B).

[4] Monopolies ⇨28(1.4)
265k23(1.4)

In order to give rise to a private cause of action, an antitrust violation must be the proximate cause of the plaintiff's injury. Clayton Act, § 4(a), 15 U.S.C.A. § 15(a).

[5] Monopolies ⇨28(1.4)
265k28(1.4)
[6] Monopolies⇨28(1.6)
265k28(1.6)

When determining whether a plaintiff's injuries suffice to provide standing for a private antitrust action, courts examine three factors: (1) whether there are more direct victims of the alleged wrongful conduct who can be counted on to vindicate the law as private attorneys general; (2) whether it will be difficult to ascertain the amount of the plaintiff's damages attributable to defendant's wrongful conduct; and (3) whether the courts will have to adopt complicated rules apportioning

damages to obviate the risk of multiple recoveries. Clayton Act, § 4(a), 15 U.S.C.A. § 15(a).

[7] Racketeer Influenced and Corrupt Organizations ⇨58
319Hk58

In order to bring a private action under Racketeer Influenced and Corrupt Organizations Act (RICO) section prohibiting investment or improper use of money obtained from racketeering activity, plaintiff must allege that he suffered injury arising from defendant's investment or improper use of racketeering income. 18 U.S.C.A. § 1962(a).

[8] Racketeer Influenced and Corrupt Organizations⇨62
319Hk62

Assignee, to whom patients' claims against employee healthplans were reassigned by health care providers, was not directly injured, as required for assignee's Racketeer Influenced and Corrupt Organization Act (RICO) claim, by plans' alleged fraudulent denial of health benefits and subsequent investment of proceeds in group of preferred medical providers in order to exclude outside providers. 18 U.S.C.A. § 1962(a).

[9] Racketeer Influenced and Corrupt Organizations⇨38
319Hk38

A group does not constitute an "enterprise" under the Racketeer Influenced and Corrupt Organizations Act (RICO) unless it exists independently from the racketeering activity in which it engages; at minimum, a RICO enterprise must have some sort of structure for the making of decisions and some mechanisms for controlling and directing the affairs of the group on an on-going, rather than an ad hoc, basis. 18 U.S.C.A. §§ 1961(4), 1962(c).

[10] Racketeer Influenced and Corrupt Organizations⇨35
319Hk35
A group whose members collectively engage in an illegal act does not, in-and-of-itself, constitute an "enterprise" under the Racketeer Influenced and Corrupt Organizations Act (RICO). 18 U.S.C.A. § 1962(c).

[11] Racketeer Influenced and Corrupt Organizations Act (RICO)⇨39
319Hk39

Employee health plans and health insurance companies that allegedly collaborated in scheme to defraud plan beneficiaries did not constitute enterprise required for private Racketeer Influenced and Corrupt Organizations Act (RICO) action, where there was nothing that showed structure to alleged collusion beyond racketeering activity itself. 18 U.S.C.A. § 1962(c).

[12] Conspiracy
91k9

Plaintiff's failure to state claims under Racketeer Influenced and Corrupt Organization Act (RICO) provisions prohibiting investment of racketeering income and conducting affairs of RICO enterprise precluded his pleading claim for conspiracy to violate either of those provisions. 18 U.S.C.A. § 1962(a,c,d).

[13] Federal Courts ⇨817
170Bk817
The Court of Appeals reviews for abuse of discretion a district court's denial of further leave to amend, and the court's discretion is particularly broad when the plaintiff previously has been granted leave to amend.

Appendix A

[14] Federal Civil Procedure ⇨1838
170Ak1838

Key question in determining whether district court properly denied plaintiff further leave to amend after dismissal is whether plaintiff could have saved his complaint through further amendment.

[15] Federal Civil Procedure ⇨ 1838
170Ak1838

District court properly denied plaintiff leave to amend his antitrust and Racketeer Influenced and Corrupt Organizations Act (RIC0) complaint after dismissal, even though it was theoretically possible for him to allege more specific facts; both claims failed due to absence of direct injury, and fact that court had already given plaintiff three opportunities to amend claims suggested futility of further amendment.
*1078 Stephen Simon, in Propria Persona, Inverness, Florida, for the plaintiff-appellant.

Bruce A. Beckman, Jeffrey P. Smith, Brian F. Rowe, Beckman, Davis, Smith & Ruddy, Los Angeles, California, for defendants-appellees Value Behavioral Health, Inc., Value Health, Inc., Preferred HealthCare Ltd., American Psychmanagement, Inc., Robert Patricelli, The Prudential Insurance Company of America, The Guardian Life Insurance Company of America, Pacific Mutual Life Insurance Company, PM Group Life Insurance Company, Blue Cross/Blue Shield of Ohio, Mutual Health Service Co., McDonough Capperton, Inc. Employee Benefit Plan and Health Management Strategies International, Inc.

Robert S. Hark, Hark & Andrucki, Lewiston, Maine, and

Jeffrey A. Modisett, Attorney General of Indiana, Indianapolis, Indiana, for defendants-appellees City of Lewiston and Maine.

Dennett F. Kouri, William E. von Behren, Brian K. Mazen, Mezerve, Mumper & Hughes, Los Angeles, California, for defendants-appellees American General Life and Accident Insurance Company, et al.

James M. Harris and Amy L. Applebaum, Sidley & Austin, Los Angeles, California, for defendants-appellees CT Corporation and CSC The United States Corporation.

Michael R. Feinberg, Schwartz, Steinsapir, Dohrmann & Sommers, Los Angeles, California, for defendants-appellees NALC Health Benefit Plan.

Mark Hanley Lipton, Granite Bay, California, for defendants-appellees Comparative Insurance Services.

Louise H. Renne, City Attorney; Patrick J. Mahoney, Chief Trial Deputy; Peter Obstler, Deputy City Attorney, San Francisco, California, for defendants-appellees City and County of San Francisco.

Thomas A. Miller and Michael S. Henderson, Robins, Kaplan, Miller & Ciresi, Costa Mesa, California, for defendants-appellees Blue Cross and Blue Shield of Minnesota, Federated Mutual Insurance Company and European Car Parts, Inc. Employee Benefit Plan.

Ronald J. Cooke and Nanette B. Zamost, Littler Mendelson, Los Angeles, California for defendants-appellees Harcourt Brace Jovanovich, Inc.

Delbert C. Gee, Sturgeon, Keller, Phillips, Gee & O'Leary, San

Francisco, California, for defendants-appellees Blue Cross & Blue Shield of Georgia, Blue Shield & Blue Cross of Maryland, Blue Shield & Blue Cross of North Dakota, Blue Shield & Blue Cross of Nebraska, and Blue Shield of California.
*1079 William M. Demlong and J. Gregory Cahill, Bess Kunz, Phoenix, Arizona, for defendants-appellees American Community National Insurance Company Employee Benefit Plan(s).

Neil J. Barker, Pasadena, California, for defendants-appellees Blue Cross and Blue Shield of Alabama.

Marc J. Wodin, Law Offices of Marc J. Woodin, Woodland Hills, California, for defendants-appellees Bankers Life and Casualty Company.

Christopher W. Tompkins, Betts, Patterson & Mines, Seattle, Washington, for defendants-appellees Swim Chem Products, Inc.; Great Lakes Chemical Corporation, BL Network, Inc. and BL Network, Inc. Employee Benefit Plan.

Alexander B. Cvitan and Esteban Lizardo, Reich, Adell, Crost & Cvitan, Los Angeles, California, for defendants-appellees Laborers Health and Welfare Trust Fund for Southern California.

Gregory H. Halliday and Deborah L. O'Connor, Sedgwick, Detert, Moran & Arnold, Irvine, California, for defendants-appellees Healthcare Compare Corp. (formerly known as HealthCare COMPARE Corp. d/b/a AFFORDABLE Medical Networks and Affordable Health Care Concepts, k/n/a First Health Group Corp.)

Sean P. Nalty and Karleen F. Murphy, Kelly, Herlihy, Advani & Klein, San Francisco, California, for defendants-appellees

United Insurance Company of America.

Robert S. Schulman and James C. Martin, Crosby, Heafey, Roach & May, Los Angeles, California, for defendants-appellees Gallagher Bassett Services, Inc.

Leon W. Weidman, Assistant United States Attorney, and Jon Pearson, Assistant United States Attorney, Los Angeles, California, for defendants-appellees United States Post Office: United States Postal Service Employee Benefit Plan; Civilian Health and Medical Programs of the Uniformed Services; United States Office of Personnel Management; United States Army; United States Army Employee Benefit Plan; United States Academy of Health Science; United States Marine Corps; United States Marine Corps Employee Benefit Plan; United States Navy; United States Navy Employee Benefit Plan; United States Air Force; United States Air Force Employee Benefit Plan; Environmental Protection Agency; Environmental Protection Agency Employee Benefit Plan; United States Forest Service; United States Forest Service Employee Benefit Plan; Federal Aviation Administration; Federal Aviation Administration Employee Benefit Plan; Veteran's Administration; Veteran's Administration Employee Benefit Plan.

Daniel W. Maguire and Ann C. Schneider, Galton & Helm, Los Angeles, California, for defendants-appellees ITT Hartford Group, Inc. and ITT Hartford Group, Inc., As Administrator and/or Trustee; General American Life Insurance Company; Genelco; Pan-American Life Insurance Company; National Insurance Services, David Koppe, William McGuire, MD; Metrahealth Care Management Corporation' United Healthcare Corporation; United HealthCare Corporation Employee Benefit Plan; United Healthcare Services, Inc.; United Behavioral Systems, Inc.; Tricon Global Restaurants

Inc.; Pepsi Co.; and Taco Bell.

Meghan K. Serwin and Michael Annis, Paula Financial, Pasadena, California, for defendants-appellees Paula Fianancial.

Margaret H. Campbell and Andrea L. Bailey, Ogletree, Deakins, Nash, Smoak & Stewart, Atlanta, Georgia, for defendants-appellees Group Resources, Inc.

Mary Hulett and Scott A. Brooks, Daniels, Baratta & Fine, Los Angeles, California, for defendants-appellees National Association of Health Underwriters,

Roland C. Bainer, Clayson, Mann, Yaeger & Hansen, Corona, California, for defendants-appellees Adventist Health System of Loma Linda; Loma Linda University; Loma Linda University Medical Center; Loma Linda University of Medical Group Inc.; Adventist Health * 1080 System of Loma Linda Employee Benefit Plan; Loma Linda University School of Medicine Health Assistance and Medical Personnel Service Plan; Loma Linda University Medical Center Employees Benefit Plan; and Loma Linda University Medical Group, Inc. Employee Benefit Plan.

Ellen Kamon, Rosato & Samuels, North Hollywood, California, for defendants-appellees Metropolitan Life Insurance Company and Jack Wickware.

Appeal from the United States District Court for the Central District of California; Gary L. Taylor, District Judge, Presiding. D.C. No. CV -96-00711-GLT.

Before: D.W. NELSON, WIGGINS, [FN2] and RYMER, Circuit Judges.

FN2. Judge Wiggins authored this Opinion prior to his death.

WIGGINS, Circuit Judge:

Appellant Stephen Simon appeals for the district court's dismissal of his civil suit against approximately 1,600 defendants in the health insurance industry. We have jurisdiction under 28 U.S.C. § 1291, and we AFFIRM.

I.

When filing this appeal, Simon requested initial en banc hearing pursuant to Rule 35 of the Federal Rules of Appellate Procedure. The judges of this circuit were notified of this request, but no judge called for an en banc vote. Simon's request is therefore denied. See Fed. R. App. P. 35(f).

II.

Over 600 mental health care patients assigned their benefit claims to at least six mental health care providers who later reassigned these claims to Simon. In June 1996, Simon filed suit to recover on these claims from approximately 1,600 defenants (collectively "Appellees") consisting primarily of insurance companies, insurance company agents, insurance industry trade groups, employee benefit plans, employers, and governmental entities. His complaint alleged, inter alia, that Appellees violated (1) the Employee Retirement Income Security Act ("ERISA"), codified at 29 U.S.C. § 1001 et seq.; (2) Section 1 of the Sherman Antitrust Act, codified at 15 U.S.C. § 1001; (3) the Clayton Act, codified at 15 U.S.C. §§ 12-27 and 29 U.S.C. §§ 52-53; and (4) the Racketeer Influenced and Corrupt Organizations Act ("RICO"), codified at 18 U.S.C. §§ 1961-1968.

Reduced to their core, these claims accuse Appellees of engaging in a mass conspiracy to withhold benefits fraudulently and to restrain trade.

[1] The district court dismissed all of Simon's claims pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. We review do novo the district court's dismissal of these claims. See Steckman v. Hart Brewing, Inc., 143 F.3d 1293, 1295 (9th Cir. 1998).

III.

[2] The first issue on appeal is whether Simon has standing under ERISA, as the assignee of other assignees, to sue on the 600-plus benefit claims that were assigned to him. In a published order, the district court held that Simon lacked standing because he was neither a participant nor a beneficiary of a health benefit plan within the meaning of ERISA and because he was ineligible for the derivative standing that health care providers enjoy. See Simon vs. Value Behavioral Health, Inc. 955 F. Supp. 93, 95-96 (C.D. Cal. 1997). The district court's interpretation of ERISA raises a question of law which we review de novo. See Arnold v. Arrow Transp. Co. of Del., 926 F.2d 782, 785 (9th Cir. 1991). We affirm the district court's decision that Simon lacked standing.

Section 502(a)(1)(B) of ERISA authorizes health benefit plan participants and beneficiaries to bring civil enforcement actions to recover plan benefits. [FN3] See 29 *1081 U.S.C. § 1132 (a)(1)(B). The Supreme Court has construed Section 502 narrowly to permit only the parties enumerated therein to sue directly for relief. See Franchise Tax Bd. V. Construction Laborers Vacation Trust for S. Cal., 463 U.S. 1, 27, 103 S.Ct. 2841, 77 L.Ed.2d 420 (1983); see also Cripps v. Life Ins. Co. of N. Am., 980 F.2d. 1261, 1264-65 (9th Cir. 1992)(following

Franchise Tax Bd. To deny insurance companies standing to sue under Section 502). Simon conceded in district court that he is neither a participant nor a beneficiary of any of the plans under which his benefit claims arise. Consequently, because he is not one of the parties enumerated in Section 502(a)(1)(B), he may not sue directly under ERISA.

> FN3. Section 502(a)(1)(B) also authorizes plan fiduciaries and the Secretary of Labor to file suit. See 29 U.S.C. § 1132(a)(1)(B). These provisions, however, do not apply to the instant case because Simon has never alleged himself to be a plan fiduciary and because he obviously is not the Secretary of Labor.

[3] Simon also lacks standing under derivative standing theory. In Misic v. Building Serv. Employees Health & Welfare Trust, 789 F.2d 1374 (9th Cir. 1985)(per curiam), we created a judicial exception to the rule that only enumerated parties may sue for benefits under Section 502(a)(1)(B). In Misic, we granted derivative standing to health care providers to whom beneficiaries had assigned their benefit claims after receiving medical care from such providers. See Misic, 789 F.2d. At 1376-79. From the record, however, it is clear that Simon' s complaint alleged no facts suggesting that he provided medical care to any of the beneficiaries of the benefit claims he holds. In fact, his complaint expressly alleged that he acquired these claims through financial transactions with the health care providers to whom the beneficiaries originally assigned their claims. Because it is clear from the face of the complaint that Simon is not a health care provider to whom a beneficiary has assigned his claim in exchange for health care, he is ineligible for derivative standing under Misic.

Simon asks us to extend Misic to cover not only health care providers but also the assignee of health care providers. We

decline. In upholding the assignment of benefit claims to health care providers in Misic, we observed that such assignment would facilitate the receipt of health care benefits by beneficiaries because, among other things, it would (1) make "it unnecessary for health care providers to evaluate the solvency of patients before commencing medical treatment" and (2) save beneficiaries from the burden of fronting potentially large medical bills while waiting for reimbursement from their health benefit plans. Misic, 789 F.2d at 1377. In other words, we granted derivative standing to health care providers not because we believed that federal common law on derivative standing trumps the plain language of Section 502. We granted it because permitting health care providers to sue in place of the beneficiaries they had treated was consistent with Congressional intent in enacting ERISA. See id.; see also Hermann Hosp. v. MEBA Med. & Benefits Plan, 845 F.2d. 1286, 1289 n. 13 (5th Cir. 1988)("To deny standing to health care providers as assignees of beneficiaries of ERISA plans might undermine Congress' goal of enhancing employees' health and welfare benefit coverage."). Granting derivative standing to health care providers simplified the billing structure among the patient, his care provider, and his benefit plan in a way that enhanced employee health benefit coverage.

In the instant case, for us to grant Simon standing would be tantamount to transforming health benefit claims into a freely tradable commodity. It could lead to endless reassignment of claims, and it would allow third parties with no relationship to the beneficiary to acquire claims solely for the purpose of litigating them. We do not see how such a result would further ERISA's purpose. Our review of the statutory text of Section 502, relevant precedent, and the legislative history of ERISA also revealed no indication that Congress intended for plaintiffs in Simon's ***1082** position to sue under ERISA. We therefore decline to extend derivative standing to Simon. Cf.

Chemung Canal Trust Co. v. Sovran Bank/Maryland, 939 F.2d 12, 14 (2d Cir. 1991)("[I]n the absence of some indication of legislative intent to grant additional parties standing to sue, the list in § 502 should be viewed as exclusive."). Because Simon lacks standing, the district court properly dismissed his ERISA claims.

IV.

Simon's antitrust claims essentially accuse Appellees of engaging in two practices: (1) operating two-tiered health plans in which patients who use network providers enjoy better benefits than those who use out-of-network providers; and (2) sharing statistical information about the usual and customary charges for medical treatment. The gravamen of these claims is that these practices constitute a restraint of trade but that drove certain out-of-network providers out of business. The district court dismissed Simon's antitrust claims on the basis of the McCarran-Ferguson Act, codified at 15 U.S.C. § 1012(b), which exempts the business of insurance from federal antitrust regulation. We affirm for a simpler reason: Simon lacks standing to assert his antitrust claims. See Steckman, 143 F.3d at 1295 (permitting affirmance of a Rule 12(b)(6) dismissal on any proper ground regardless of whether the district court relied on that ground).

[4][5] Federal antitrust laws provide a private right of action only to individuals who are "injured in [their] business or property by reason of" a federal antitrust violation. 15 U.S.C. § 15(a). The violation must be the proximate cause of the injury. See Blue Shield of Virginia v. McCready, 457 U.S. 465, 477, 102 S.Ct. 2540, 73 L.Ed.2d 149 (1982); Oregon Laborers-Employers Health & Welfare Trust Fund v. Philip Morris Inc., 185 F.3d 957, 963 (9th Cir. 1999), cert. denied, —U.S.—, 120 S.Ct. 789, 145 L.Ed.2d 666 (2000). When determining whether a

plaintiff's injuries suffice to grant him standing to sue, we examine three factors: "(1) whether there are more direct victims of the alleged wrongful conduct who can be continued on to vindicate the law as private attorneys general; (2) whether it will be difficult to ascertain the amount of the plaintiff's damages attributable to defendant's wrongful conduct; and (3) whether the courts will have to adopt complicated rules apportioning damages to obviate the risk of multiple recoveries." Oregon Trust Fund, 185 F.3d at 963.

[6] In the instant case, there are more direct victims of Appellees' allegedly illegal conduct. To the extent that Appellees' practices drove certain health care providers out of business, it was the providers who suffered the injury. To the extent that Appellees' practices restricted a plan beneficiary's access to mental health care, it was the beneficiary who suffered the injury. Simon's connection to the alleged victims is at best one-step removed: He is merely the assignee of benefit claims. He is neither an injured beneficiary nor an injured health care provider, and thus the first factor weighs heavily against him.

The second and third factors also do not favor Simon. Because Simon never alleged how he himself has been injured by Appellees' actions, it is impossible to ascertain how much of such injury is attributable to Appellees' conduct or whether the apportionment of damages will require complex rules. Even if we were to assume that Simon was injured by the loss of whatever consideration he paid in exchange for the assignment of the benefit claims, we still would face the difficult task of determining how much of the antitrust injury to the health care providers should be imputed onto the beneficiaries and then further imputed onto Simon. After this task is done, we then would face the even more difficult task of apportioning damages. Although it is unclear whether this case implicates

a risk of multiple recovery, apportioning damages would be complicated by virtue of the complexity of Appellees' interactions.

*1083 In sum, no factor supports Simon, and the first factor in particular weighs heavily against him. We therefore find that Simon lacks standing to assert his antitrust claims and affirm their dismissal by the district court. See id. at 963-966 (denying standing to a plaintiff who did not suffer a direct injury from the defendant's conduct).

V.

The last set of substantive issues concerns Simon's RICO claims. In his complaints, Simon alleged that Appellees engaged in a pattern of racketeering activity in violation of 18 U.S.C. §§ 1962(a), 1962(c) & 9162(d). But because his complaint failed to alleged either an injury caused by the investment of racketeering income or the existence of a RICO enterprise, we affirm the dismissal of his RICO claims.

(A) 18 U.S.C. § 1962(a)

[7] Section 1962(a) prohibits the investment of improper use of money obtained from racketeering activity. See 18 U.S.C. § 1962(a). In order to plead a Section 1962(a) claim, Simon must allege that he suffered injury arising from Appellees' investment or improper use of racketeering income. See Nugget Hydroelectric, L.P. v. Pacific Gas & Elec. Co., 981 F.2d 429 (9th Cir. 1992).

[8] Simon's complaint alleged that Appellees fraudulently denied health benefit claims and then invested the proceeds to develop a group of preferred medical providers who operated to eliminate outside providers. Assuming arguendo that this

conduct constitutes an illegal investment of racketeering income, Simon still has not alleged any injury to himself. Any injury caused by the investment was to the outside medical providers who were allegedly driven out of business by the preferred providers. Nowhere did Simon allege that Appellees' investment drove him out of business or harmed him directly in some way. His failure to plead this requisite element means that he has failed to plead a cognizable Section 1962(a) claim. See Oregon Trust Fund, 185 F.3d at 964 (stating that a "direct relationship between the standing in a private RICO claim).

(B) 18 U.S.C. § 1962(c)

[9][10] Section 1962(c) prohibits association with an "enterprise" engaged in racketeering activity. See 18 U.S.C. § 1962(c). In order to plead a Section 1962(c) violation, Simon must allege that Appellees were associated with an "enterprise" within the meaning of RICO. See Resolution Trust Corp. v. Keating, 186 F.3d 1110, 1117 (9th Cir. 1999). The definition of "enterprise" encompasses both groups with a formal legal structure and those whose members merely associate in fact. See 18 U.S.C. § 1961(4). Either way, however, a group does not constitute an enterprise unless it exists independently from the racketeering activity in which it engages. See Chang v. Chen, 80 F.3d 1293, 1298 (9th Cir. 1996)(citing United States v. Turkette, 452 U.S. 576, 583, 101 S.Ct. 2524, 69 L.Ed.2d 246 (1981)). At minimum, it must have "some sort of structure...for the making of decisions" and "some mechanism for controlling and directing the affairs of the group on an on-going, rather than an ad hoc basis." Id. at 1299 (internal quotations omitted). A group whose members collectively engage in an illegal act, in-and-of-itself, does not constitute an "enterprise" for the purposes of RICO. See id. at 1300.

[11] Simon's complaint alleged no more than that Appellees collaborated to defraud health plan beneficiaries. But a "conspiracy is not an enterprise for the purposes of RICO." Chang, 80 F.3d at 1300. As in Chang, Simon did not allege facts that showed a structure to Appellees' collusion beyond the racketeering activity itself. See id. He never alleged the existence of a system of authority that guided the operation of the enterprise. He never alleged that Appellees "utilized a structure separate and apart from the predicate acts to distribute the proceeds of the [allegedly ***1084** fraudulent] transactions." Id. Given the absence of any alleged facts suggesting the existence of an enterprise, he has failed to state a cognizable Section 1962(c) claim. See id. at 1301.

(C) 18 U.S.C. § 1962(d)

[12] Section 1962(d) prohibits the act of conspiring to violate. Section 1962(a) or Section 1962(c). See 18 U.S.C. § 1962(d). Simon's failure to plead the requisite elements of either a Section 1962(a) or a Section 1962(c) violation implicitly means that he cannot plead a conspiracy to violate either section. See Religious Tech. Ctr. v. Wollersheim, 971 F.2d. 364, 367 n. 8 (9th Cir. 1992); see also Neibel v. Trans World Assurance Co., 108 F.3d 1123, 1127 (9th Cir. 1997)("[I]f the section 1962(c) claim does not state an action upon which relief could ever be granted...then the section 1962(d) claim cannot be entertained."). We thus affirm the dismissal of this Section 1962(d) claims.

VI.

[13][14] In dismissing Simon's Third Amended Complaint, the district court denied him further leave to amend his antitrust and RICO claims. Simon argues that this denial constitutes error. We review for abuse of discretion the district court's

denial of further leave to amend. See Griggs v. Pace Amer. Group, Inc. 170 F.3d 877,870 (9th Cir. 1999). The district court's discretion "is particularly broad" when the plaintiff previously has been granted leave to amend. Id. The key question is whether Simon could have saved his complaint through further amendment. See id. We conclude that he could not.

[15] As discussed above, Simon's antitrust claims suffer from a fatal defect: The absence of direct injury. His RICO claims suffered from the same defect and from the absence of a racketeering enterprise. Although it is theoretically possible for Simon to allege more specific facts, his failure to do so after the district court had given him three opportunities to amend his original complaint and had discussed with him the substantive problems with his claims suggests the futility of further amendment. We therefore find no abuse of discretion in the district court's refusal to grant Simon to leave to amend his Third Amended Complaint. See Siseton-Wahpeton Sioux Tribe v. United States, 90 F.3d 351, 356 (9th Cir. 1996)(affirming denial of leave to amend when further amendment would have been futile and when the plaintiff had already been given prior opportunities to amend).

Simon also appeals the district court's denial of leave to amend the ERISA claims in his First Amended Complaint. We again affirm. As discussed above, Simon is neither a plan participant, a plan beneficiary, a health care provider, a plan fiduciary, nor the Secretary of Labor-the only people that the Ninth Circuit has recognized as having standing to sue for benefits under ERISA. Further amendment will not change the fact that he is not one of these five types of people.

VII.

Finally, Simon challenges a number of procedural rulings that

the district court made over the course of the litigation. [FN4] We decline to evaluate the merits of these rulings because any error by the district *1085 court would have been harmless. Even if Simon were entitled to more time to serve process upon Appellees, to join additional defendants to his lawsuit, or to have discovery proceed immediately, he still bore the burden of pleading a cognizable claim. Given that the claims in his complaint were substantively inadequate, they still would not have survived dismissal under Rule 12(b)(6) even if the district court had ruled in his favor on any of the procedural rulings he now challenges.

> FN4. The district court rulings contested by Simon include: (1) allowing Simon only 90 days to serve his First Amended Complaint; (2) refusing to grant Simon additional time beyond those 90 days to serve his First Amended Complaint; (3) dismissing all unserved defendants; (4) ordering Simon to revive the corporate status of two corporations who had assigned benefit claims to him; (5) staying discovery; (6) quashing the service of numerous administrators and trustees of various ERISA employee benefit plans; (7) refusing to grant Simon additional time to serve his Second Amended Complaint; (8) dismissing sua sponte and without prejudice all named defendants except Value Behavioral Health; and (9) denying Simon leave to join additional parties to his Third Amended Complaint.

AFFIRMED.

Appendix B

955 F.Supp. 93
97 Daily Journal D.A.R.
(Cite as: 955 F.Supp. 93)

United States District Court,
C.D. California,

STEPHEN SIMON, Plaintiff,
v.
VALUE BEHAVIORAL HEALTH INC., et al.,
Defendants.

No. SA CV 96-711 GLT [CC]

March 5, 1997.

Third party, holding assigned claims from six health care providers and over 600 individual participants or beneficiaries, sued over 1,600 defendants to recover Employee Retirement Income Security Act (ERISA) benefits allegedly due. Defendants moved to dismiss. The District Court, Taylor, J., held that third party, who was not health care provider, lacked standing to sue on assigned claim for ERISA benefits.

Motions granted.

West Headnotes

Pensions ⇨139
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Third party, who was not health care provider, lacked standing to sue on assigned claim for ERISA benefits payment. Employee Retirement Income Security Act of 1974, § 502(a), 29 U.S.C.A. § 1132(a).

*94 Stephen Simon, Jupiter, FL, pro per.

Audrey Lyness, Barger & Wolen, Los Angeles, CA, Bruce Beckman, Jeffrey Smith, Beckman, Davis, Smith & Ruddy, L.L.P., Los Angeles, CA, Geoffrey Glass, Robins, Kaplan, Miller & Ciresi, Costa Mesa, CA, Guy O. Kornblum, Jeffrey J. Fowler, Bailey & Kornblum, San Francisco, CA, James P. Collins, Jr., Cotkin & Collins, Santa Ana, CA, Dale F. Kinsella, Jack G. Cairl, Jr., Alan R. Kossoff, Kinsella, Boesch, Fujikawa & Towle, Los Angeles, CA, Gregory H. Halliday, Michael J. Khouri, Deborah L. O'Connor , Sedgwick, Detert, Moran & Arnold, Irvine, CA, Erica S. Arouesty, Stephen L. Hewitt, Hewitt & Prout, North Hollywood, CA, Dennett F. Kouri, Sr., Geoffrey Tong, Meserve, Mumper & Hughes, Los Angeles, CA, Kirk A. Patrick, Gibson, Dunn & Crutcher, Los Angeles, CA, Ellen Kamon, Rosato & Samuels, North Hollywood, CA, Daniel W. Maguire, Mark Riekhof, Galton & Helm, Los Angeles, CA, Gordon E. Krischer, Kenneth E. Johnson, O'Melveny & Myers, L.L.P., Los Angeles, CA, Kenneth L. Schmetter, Senior Supervising Attorney, City of Chicago, Department of Law, Chicago, IL, Patrick J. Mahoney, Chief Trial Attorney, Margaret W. Baumgartner, Deputy City Attorney, San Francisco, CA Marta M. Fernandez, Rebecca L. Torrey, Lynne M. Hook, Jeffer, Mangels, Butler, & Marmaro, Los Angeles, CA Jeffrey L. Sikkema, Juan C. Basombrio, Dorsey & Whitney, L.L.P., Costa Mesa, CA, Ronald J. Cooke, Meghan A. White, Littler, Mendelson, Fastiff, Tichy & Mathiason, Los Angeles, CA, Mark A. Wooster, Universal City, CA, J. Thomas Bowen, Davis Cowell & Bowe, San Francisco, CA, Roland C. Bainer, Clayson, Mann & Yaeger, Corona, CA, Marc J. Woodin, Law Offices of Marc J. Wodin, Woodland Hills, CA, J. Mark Waxman, Jonathon E. Cohn, Foley, Lardner, Weissburg & Aronson, Los Angeles, CA, Patrick T. Connor, DeCarlo, Connor & Selvo, Los Angeles, CA, Michael R. Feinberg, Los Angeles, CA, David C. Capell, J. Matthew Patton, Gordon &

Rees, L.L.P., San Francisco, CA Ronald J. Hein, Jr. Terrence T. Creamer, Chicago, IL, Sean P. Nalty, Wyne A. Aher, Kelly & Herlihy, San Francisco, CA, Keith M. Parker, Rachelle Singer, Irvine, CA, Stephen M. Harris, Diron M. Ohanian, Knapp, Petersen & Clarke, Glendale, CA, Elizabeth W. Walker, Paul, Hastings, Janofsky & Walker, Los Angeles, CA, Alexander B. Cvitan, Esteban Lizardo, Darren Goodman, Reich, Adell, Crost & Cvitan, Los Angeles, CA, Ted L. Wilkes, New York City, Robert J. Stumpf, Jr. Lyn A. Bersch, Bronson & Bronson & McKinnon, L.L.P., San Francisco, CA, Stephanie L. Chilton, Hermosa Beach, CA, Robert L. Dysart, Bess & Dysart, Phoenix, AZ, W. Mark Wood, Phillip R. Kaplan, Todd A. Green, O'Melveny & Myers, L.L.P. Newport Beach, CA, Margaret H. Campbell, Andrea L. Bailey, Ogletree, Deakins, Nash, Smoak & Stewart, P.C., Atlanta, GA, John Provost, Beeson, Tayer & Bodine, Sacramento, CA, Lesley C. Green, Los Angeles, CA, Diane C. Blasdel, Selzer, Ealy, Hemphill & Blasdel, Rancho Mirage, CA, Scott A. Brooks, Daniels, Baratta & Fine, Los Angeles, CA, Robert S. Schulman, Linda Margolies Salem, Crosby, Heafey, Roach & May, Los Angeles, CA, Meghan K. Serwin, Paula Financial Inc., Pasadena, CA., Paul Alexander, Vanessa Wells, Palo Alto, CA, Richard J. Foster, Paone, Callahan, McHOlm & Winton, Irvine, CA, Peter E. Romo, Jr. Horace W. Green, Seyfarth, Shaw, Fairweather & Gerald, San Francisco, CA, Phillip M. Miller, Saltzman & Johnson Law Corp., San Francisco, CA, Mark Lipton, Lipton, Warnlof & Segal, Walnut Creek, CA, Jacob J. Stettin, Stettin, & Cass, Los Angeles, CA, Robert S. Hark, Lewiston, ME, Patrick M. Smith, Nugent & Newnham, A.P.C., San Diego, CA, Ronald K. Alberts, Jeffrey A. Katz, Frye, Alberts & Malchow, Los Angeles, CA, Neil J. Barker, Gronemeier & Barker, Pasadena, CA, Marc A. Becker, Munger, Tolles & Olson, L.L.P., Los Angeles, CA, David T. DiBiase, Regina R. Wong, Los Angeles, CA Jana I. Lubert, Lewis, D'Amato, Brisbois & Bisgaard, Los Angeles, CA Marc Epstein, Gaims, Weil, *95 West & Epstein,

L.L.P., Los Angeles, CA, Judith A. Ripps, Harnett Lesnick & Ripps, P.A., Boca Raton, FL, Douglas A. Kuber, Quinn, Emanuel Urquhart & Oliver, L.L.P., Los Angeles, CA, Scott D. Norton, Sullivan, Ward, Bone, Tyler & Asher, P.C., Southfield, MI, Owen Strange, Booth, Michael & Strange, L.L.P., Los Angeles, CA, for Defendants.

ORDER GRANTING DEFENDANTS' MOTIONS TO DISMISS

TAYLOR, District Judge.

The Court holds a third party who is not a health care provider lacks standing to sue on an assigned claim for ERISA benefits payment.

Plaintiff sues over 1,600 defendants to recover ERISA benefits allegedly due. Although not a health care provider, Plaintiff holds assigned claims from six health care providers and over 600 individual participants or beneficiaries. [FN1]

> FN1. Plaintiff was not assigned these claims from the individuals themselves. Apparently, he received these assignments from six health care providers who had the claims assigned to them by the individuals. Thus, Plaintiff is the assignee of an assignee.

Under the Employees Retirement Income Security Act of 1974 (ERISA), plan participants or beneficiaries are permitted to bring civil enforcement actions to recover plan benefits. 29 U.S.C. § 1132(a)(1)(B). A "participant" is defined as "any employee..." who is or may become eligible to receive a benefit of any type from an employee benefit plan..." 29 U.S.C. § 1002(7). A "beneficiary" is defined as a "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29

Appendix B

U.S.C. § 1002(8).

ERISA creates "six carefully integrated civil enforcement provisions" which identify who may pursue a claim under the statute. Massachusetts Mutual Life Inc. Co. v. Russell, 473 U.S. 134, 146, 1095 S.Ct. 3085, 3092, 87 L.Ed.2d 96 (1985). The Ninth Circuit has held ERISA does not forbid a beneficiary from assigning a right of reimbursement under a medical plan to his health care provider. Misic v. Building Services Employees Health and Welfare Trust, 789 F.2d. 1374, 1377 (9th Cir. 1986). But, Plaintiff fails to present persuasive authority supporting standing of a third party ERISA claim assignee other than the beneficiary's health care provider.

> FN2. In Misic, the court concluded that ERISA did not forbid a health care provider assignment because "the general goal of the statute would [not] be served by prohibiting the type of assignments involved in this case." 789 F.2d at 1377. Unlike in Misic, Plaintiff here does not have the same personal interest in dealing directly with the trust fund as does a health care provider.

Other courts have permitted standing based on assignments of ERISA claims to health care providers. Se Lutheran Medical Center v. Contractors, Laborers, Teamsters, and Engineers Health and Welfare Plan, 25 F.3d 616, 620 (8th Cir. 1994); Hermann Hospital v. MEBA Medical & Benefits Plan, 845 F.2d 1286, 1290 (5th Cir. 1988); Protocare of Metropolitan N.Y., Inc. v. Mutual Ass'n Administrators, Inc., 866 F.Supp. 757, 762 (S.D.N.Y. 1994); Care Unit Hospital v. Travelers Companies, 787 F.Supp 750, 753 (S.D. Ohio 1991); Belmont Community Hospital v. Local Union No. 9, 737 F.Supp. 1034, 1037 (N.D. Ill. 1990). But see Northeast Dept. ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund, 764 F.2d

147, 14 n. 6 (3d Cir. 1985)(expressing "serious doubts" over whether assignment of ERISA claims was valid under 29 U.S.C. § 1132(a)(1)(B)). However, apparently no court has recognized an assignment to a third party who is not a health care provider.

Without further authority from the Ninth Circuit, this Court will not "tamper with an enforcement scheme crafted with such evident care," Massachusetts Mutual, 473 U.S. at 147, 105 S.Ct. at 3093, and recognize the standing of a third party not specifically authorized by Congress in section 1132(a). The Ninth Circuit and other circuits have expanded that class to health care providers, but this Court will not expand it further. Accordingly, the Court holds Plaintiff does not have standing to pursue assigned claims for payment of ERISA benefits. Defendants' ***96** Motions to Dismiss Plaintiff's ERISA claims are GRANTED without leave to amend.

APPENDIX C

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

STEPHEN SIMON, an individual and as assignee of assignors, Plaintiff-Appellant, v. VALUE BEHAVIORAL HEALTH, INC., GUARDIAN LIFE INSURANCE OF AMERICA; VALUE HEALTH INC.; ROBERT E. PATRICELLI, LTD; AMERICAN PSYCHMANAGEMENT, INC; PREFERRED HEATLHCARE, LTD; HEALTH MANAGEMENT STRATEGIES INTERNATIONAL, INC.; THE PRUDENTIAL INSURANCE COMPANY; HEALTHCARE SYSTEMS, INC.; HEALTH RISK MANAGEMENT OF AMERICA; JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY; JOHN ALDEN LIFE INSURANCE COMPANY; COSTCARE, INC.; JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY EMPLOYEE BENEFIT PLAN; BLUE	No. 98-55905 D.C. No. CV-96-0711 GLT ORDER

CROSS & BLUE SHIELD ASSOCIATION; BLUE CROSS & BLUE SHIELD OF ILLINOIS, INC.; BLUE CROSS/BLUE SHIELD OF IOWA, INC.; BLUE CROSS/ BLUE SHIELD OF KANSAS, INC.; BLUE CROSS/BLUE SHIELD OF MASSACHUSETTS, INC.; BLUE CROSS/BLUE SHIELD OF MICHIGAN, INC.; EMPIRE BLUE CROSS/BLUE SHIELD; NEW YORK LIFE INSURANCE COMPANY; BLUE CROSS/BLUE SHIELD OF TEXAS, INC., Administrator and/or Trustee on Behalf of Paune Extrusions Company Employee Benefit Plan; BLUE CROSS/BLUE SHIELD OF VIRGINIA, INC., Administrator and/or Trustee on Behalf of Commonwealth University Employee Benefit Plan, Metro Inc. Information Services Employee Benefit Plan, Department of Motor Vehicles of the Commonwealth of Virginia Employee Benefit Plan, Linsky Plant Farm, Inc. Employee Benefit Plan, Memorial Hospital, Inc., Employee Benefit Plan, Virginia Polytechnic Institute and State University Employee Benefit Plan, Campbell County Transport Employee Benefit Plan, Hodgerman's Company Employee Benefit Plan, AMERICAN

APPENDIX C

GENERAL LIFE & ACCIDENT INSURANCE CO., Administrator and/or Trustee on Behalf of American General Life & Accident Insurance Company Employee Benefit Plan; BENEFIT TRUST LIFE, Administrator and/or Trustee on Behalf of Lagrange Country Club, Inc. Employee Benefit Plan, Wood Tech, Inc. Employee Benefit Plan; BLUE CROSS OF ALASKA; BLUE CROSS OF WASHINGTON; SPECIALTY MEDICAL CLINIC EMPLOYEE BENEFIT PLAN, BELL ATLANTIC CORPORATION: C & P TELEPHONE; TUTHILL CORPORATION; FKW, INC; BLUE CROSS/BLUE SHIELD OF MINNESOTA; BLUE CROSS/BLUE SHIELD OF MAINE; BANKERS LIFE AND CASUALTY COMPANY; NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS; CITY OF LEWISTON SCHOOL DEPARTMENT RELIASTAR LIFE INSURANCE COMPANY; PPG INDUSTRIES, INC.; VENTURA INSURANCE ADMINISTRATORS, INC.; VENTURA COUNTY FOUNDATION FOR MEDICAL CARE, INC.; A & P GROCERY STORE, INC.; A & P GROCERY STORE, INC. EMPLOYEE BENEFIT PLAN; CRAWFORD

INSURANCE COMPANY; SECURITY BENEFIT TRUST FUND, ROOFERS LOCAL 149 SECURITY BENEFIT TRUST FUND; ROOFERS LOCAL 149 EMPLOYEE BENEFIT PLAN; ITT HARTFORD GROUP, INC., ITT HARTFORD GROUP, INC., As Administrator and/or Trustee; GENERAL AMERICAN LIFE INSURANCE COMPANY; GENELCO; PAN AMERICAN LIFE INSURANCE COMPANY; NATIONAL INSURANCE SERVICES; DAVID KOPPE; WILLIAM McGUIRE M.D.; METRAHEALTH CARE MANAGEMENT CORPORATION; UNITED HEALTHCARE CORPORATION; UNITED HEALTHCARE CORPORATION EMPLOYEE BENEFIT PLAN; UNITED HEALTHCARE SERVICES, INC.; UNITED BEHAVIORAL SYSTEMS, INC.; OPERATING ENGINEERS LOCAL 37 HEALTH AND WELFARE FUND; CAPPCARE, INC.; MICHAEL HENRY; HEALTH INTERNATIONAL, INC.; erroneously sued as HEALTH INTERNATIONAL CORP.; STANISLAUS FOUNDATION FOR MEDICAL CARE; EXECUTIVE RISK; BENEFIT PANEL SERVICES; GREAT-WEST LIFE ASSURANCE COMPANY; ROCKY MOUNTAIN

MEDICAL SERVICES, dba BLUE CROSS AND BLUE SHIELD OF COLORADO; CARPENTERS HEALTH AND WELFARE TRUST FOR SOUTHERN CALIFORNIA, CARPENTERS PENSION TRUST FOR SOUTHERN CALIFORNIA; CARPENTERS SOUTHERN CALIFORNIA ADMINISTRATIVE CORPORATION; MILLWRIGHTS LOCAL UNION NO. 1607; CARPENTERS LOCAL UNION NO. 1506; CHICAGO DISTRICT COUNCIL OF CARPENTERS WELFARE FUND; CHICAGO DISTRICT COUNCIL OF CARPENTERS PENSION FUND; RETAIL CLERKS-EMPLOYERS BENEFIT PLANS OF NORTHERN CALIFORNIA AND VALLEY CLERKS TRUST FUND; CT CORPORATION, CSC THE UNITED STATES CORPORATION; BLUE CROSS/ BLUE SHIELD OF CALIFORNIA; METROPOLITAN LIFE INSURANCE COMPANY, Administrators and/or Trustee on Behalf of: Sears, Roebuck & Co. Group Medical Plan, Chemical Bank, Inc. Employee Benefit Plan, New York State Freeway Authority Employee Benefit Plan, New York State Department Civic Employee Benefit Division, Tenneco/J.I. Case

Co. Employee Benefit Plan, Sun Chemical Corporation Employee Benefit Plan, Dunn & Bradstreet Employee Benefit Plan, Rockwell International, Inc. Employee Benefit Plan, ZEP Manufacturing Company Employee Benefit Plan, National Services Industries, Inc. Employee Benefit Plan, F.W. Woolworth Company Employee Benefit Plan, Nordstrom's Inc. Employee Benefit Plan, Town of New Paltz Employee Benefit Plan, Trustees of the American Engineers Council Treasure Trust Fund, Felker Benefit Services, Pepsico, Inc. Employee Benefit Plan, Ukiah Unified School District Employee Benefit Plan, Louisiana-Pacific Inc. Employee Benefit Plan, General Electric Company Employee Benefit Plan, Proctor & Gamble Corporation Employee Benefit Plan, City of Culver Employee Benefit Plan, California Conservation Corp Employee Benefit Plan, Allcare Plan, Transport International Tools, Inc. Employee Benefit Plan, Wood Company Employee Benefit Plan, Montgomery Ward, Inc. Employee Benefit Plan, R.H. Macy's, Inc. Employee Benefit Plan, McDonough Capperton, Inc. Employee Benefit

Plan, Toys R Us, Inc. Employee Benefit Plan, J.I. Case Power & Equipment, Inc. Employee Benefit Plan; METRAHEALTH, WILLIAM W. MCGUIRE, M.D.; DAVID KOPPE; UNIFIED BEHAVIORAL SYSTEMS, INC.; NATIONAL ASSOCIATION OF LIFE UNDERWRITERS; SOUTHWESTERN BELL EMPLOYEE BENEFIT PLAN; UNIVERSAL CITY STUDIOS, INC., UNIVERSAL STUDIOS EMPLOYEE BENEFIT PLAN; MUTUAL OF OMAHA; HEALTHCARE COMPARE CORPORATION; HEALTH RISK MANAGEMENT, INC.; BENEFIT ADMINISTRATORS, INC.; CARE AMERICA, INC.; UNIFORMED SERVICE BENEFIT PLAN, INC.; U.S. POSTAL SERVICE; YUMA PROVING GROUND; U.S. ARMY; U.S. MARINE CORPS; U.S. NAVY; U.S. AIR FORCE; U.S. COAST GUARD; UNITED STATES OF AMERICA; FIRST HEALTH, INC.; GREAT WEST LIFE ASSURANCE COMPANY; BLUE CROSS/BLUE SHIELD OF ALABAMA SERVICE MASTER, INC. EMPLOYEE BENEFIT PLAN; GARY METHODIST HOSPITAL, INC. EMPLOYEE BENEFIT PLAN; LEWISTON SCHOOL; MAINE STATE CORRECTIONAL INSTITUTION

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EMPLOYEE BENEFIT PLAN; BLUE CROSS/BLUE SHIELD OF OREGON, INC., Administrator and/or Trustee on Behalf of: Safeway Stores, Inc. Employee Benefit Plan, Painters Local 10 Employee Benefit Plan, John Q. Hammonds Hotels, Inc. Employee Benefit Plan; ADVENTIST HEALTH SYSTEM OF LOMA LINDA, Administrator and/or Trustee on Behalf of Loma Linda School of Medicine Health Assistance and Medical Personnel Services Plan; LOMA LINDA SCHOOL OF MEDICINE HEALTH ASSISTANCE AND MEDICAL PERSONNEL SERVICES PLAN; UNITED CHAMBERS INSURED PLANS; AMERICAN GENERAL LIFE & ACCIDENT INSURANCE CO., Administrator and/or Trustee on Behalf of American General Life & Accident Insurance Co. Employee Benefit Plan; AMERICAN COMMUNITY MUTUAL INSURANCE CO.; AMERICAN TRUST ADMINISTRATORS; AUTOMOTIVE INDUSTRIES WELFARE FUND MEDICAL PLAN, BROWN GROUP INSURANCE CO., Administrators and/or Trustee on Behalf of Brown Group Insurance

Co. Healthcare Plan; BANKERS LIFE & CASUALTY COMPANY, Administrator and/or trustee on Behalf of City of Chicago Employee Benefit Plan; THE VOLLRATH COMPANY, INC. THE VOLLRATH COMPANY, INC. EMPLOYEE BENEFIT PLAN; CHUBB LIFE AMERICA; COMPARITIVE INS SERV; MCDONNELL DOUGLAS CORP./DOUGLAS AIRCRAFT COMPANY; SCREEN ACTORS GUILD-PRODUCERS PENSION PLAN; SWIN CHEM PRODUCTS, INC., GREAT LAKES CHEMICAL, INC.,; BL NETWORK, INC. EMPLOYEE BENEFIT PLAN; GROUP RESOURCES, INC.; HARCOURT BRACE JOVANOVICH, INC.; HEALTH ECONOMICS CORPORATION; CITY/COUNTY OF SAN FRANCISCO; INSURANTIONAL INSURANCE ADMINISTRATORS, INC.; INTERMOUNTAIN ADMINISTRATORS, INC.; LABORERS HEALTH & WELFARE TRUST FOR SOUTHERN CALIFORNIA; MCDOWELL AGENCY INC.; MUTUAL ASSURANCE; SAN FRANCISCO PRINT INDUSTRY WELFARE FUND, and Newspaper & Periodical Driver's & Helper's Union

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Local 921 - Publisher's Welfare Trust
PAVERS AND ROAD BUILDERS DISTRICT COUNCIL WELFARE FUND; JACK WICKWARE; IBEW-NECA SOUTHWESTERN HEALTH AND BENEFIT FUND; WAL-MART, INC.; WAL-MART, INC. ASSOCIATES GROUP HEALTH PLAN STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY; GROUP HEALTH INCORPORATED; FEDERATED MUTUAL INSURANCE COMPANY; EUROPEAN CARE PARTS, INC.; EMPLOYEE BENEFIT PLAN; F.W. WOOLWORTH COMPANY EMPLOYEE BENEFIT PLAN; F.W. WOOLWORTH CO.; PAULA ASSURANCE CO.; PAN AMERICAN UNDERWRITERS, INC.; GALLAGHER BASSETT SERVICES, INC.; EMPLOYEE BENEFITS ADMINISTRATION AND MANAGEMENT CORPORATION; MILK & ICE CREAM EMPLOYEES WELFARE PLAN; BLUE CROSS BLUE SHIELD OF DELAWARE, Blue Cross Blue Shield of Kentucky; Blue Cross Blue Shield of New Jersey; Blue Cross/Blue Shield of Connecticut; UNITED INSURANCE COMPANY OF AMERICA; NALC HEALTH BENEFIT PLAN; INDIANA

APPENDIX C

CHILD PROTECTIVE SERVICES;
NORTHERN INDIANA STATE
DEVELOPMENTAL CENTER;
NORTHERN INDIANA STATE
DEVELOPMENTAL CENTER;
COLUMBIA HCA HEALTHCARE
CORPORATION;

Defendants-Appellees

Before: D.W. NELSON and RYMER, Circuit Judges:

Judges D.W. Nelson and Rymer have voted to deny the petition for rehearing. Judge Rymer votes to deny the petition for rehearing en banc and Judge D.W. Nelson so recommends.

The full court has been advised of the petition for en banc rehearing, and no judge of the court has requested a vote on whether to rehear the matter en banc Fed. R. App. 35.

The petition for rehearing and petition for rehearing en banc are DENIED.

Simon's request for modification of the opinion and motion for stay of mandate are DENIED.

The panel concludes that there is no merit to Simon's argument that this court lacks jurisdiction, and to the extent that his argument can be construed as a motion to dismiss, it is DENIED.

IF THE SUPREME COURT ALLOWS PATIENTS TO SUE HMOs, HOW WILL WE HANDLE IT?
WE COULD STOP DENYING LEGITIMATE CLAIMS AND PUT HEALTH CARE BEFORE PROFITS.
HMO
YEAH, RIGHT. OK, ANY OTHER IDEAS?
HMO
MIKESMITH

APPENDIX D

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Supreme Court, U.S.
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(2)

No. 00-801

In The

Supreme Court of the United States

STEVEN SIMON,

Petitioner,

vs.

VALUE BEHAVIORAL HEALTH, INC., ET AL.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth District

OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

HARRY W.R. CHAMBERLAIN II
Counsel of Record
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Attorneys for Respondents Metropolitan Life Insurance Company and Jack Wickware, Esq.

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CORPORATE DISCLOSURE STATEMENT

MetLife, Inc., is the parent company of Metropolitan Life Insurance Company. As of September 30, 2000, publically held companies of which MetLife, Inc., directly or indirectly has actual ownership (for its Own Account) of 10% *through 99% of the total outstanding voting stock or control* are as follows:

Dan River, Inc. (GA)

Nvest, L.P. (DE)

Reinsurance Group of America, Incorporated (MO)

Companies of which MetLife, Inc. directly or indirectly has actual ownership (for its Own Account) of 10% through 99% of the *total outstanding voting stock*[1] are as follows:

AEW Advisors, Inc. (48.13%) (MA)
AEW Capital Management, Inc. (48.13%) (MA)
AEW Capital Management, L.P. (48.13%) (DE)
AEW Curzon Limited (48.13%) (England)
AEW Hotel Investment Corporation (48.13%) (MA)
AEW Hotel Investment Limited Partnership (48.13%) (MA)
AEW II Corporation (48.13%) (MA)
AEW Investment Group, Inc. (48.13%) (MA)
AEW Management and Advisors, L.P. (48.13%) (DE)

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[1] Does not include real estate joint ventures and partnerships of which MetLife, Inc. and/or its subsidiaries is an investment partner.

CORPORATE DISCLOSURE STATEMENT
– Continued

AEW Partners III, Inc. (48.13%) (DE)
AEW Partners IV, Inc. (48.13%)
AEW Real Estate Advisors, Inc. (48.13%) (MA)
AEW Real Estate Advisors, Limited Partnership (48.13%) (MA)
AEW Securities, L.P. (48.13%) (MA)
AEW TSF, Inc. (48.13%) (DE)
AEWPN, LLC (48.13%) (DE)
American Horizon General Agency, Inc. (57.2%) (FL)
American Horizon Holdings, Inc. (57.2%) (DE)
American Horizon Insurance Company (57.2%) (AZ)
American Horizon Property & Casualty Insurance Company (57.2%) (IL)
American Horizon Services, Inc. (57.2%) (DE)
Aurora Limited Partnership (0.005%) (IL)
Back Bay Advisors, Inc. (48.13%) (MA)
Back Bay Advisors, L.P. (48.13%) (DE)
BCOP Associates L.P. (0.46%) (MA)
Benefit Resource Life Insurance Company (Bermuda) Ltd. (48.13%) (Bermuda)
Copley Properties Company, Inc. (48.13%) (MA)
Copley Properties Company II, Inc. (48.13%) (MA)
Copley Properties Company III, Inc. (48.13%) (MA)
Copley Public Partnership Holding, L.P. (48.13%) (DE)
Crea Investors/Santa Fe Springs, Inc. (48.13%) (MA)
Dan River, Inc. (32%) (GA)
Eclipse Claim Services, Inc. (25%) (Canada)
Eighth Copley Corp. (48.13%) (MA)

CORPORATE DISCLOSURE STATEMENT
– Continued

Fairfield Management Group, Inc. (48.13%) (MO)
Fifth Copley Corp. (48.13%) (MA)
Fifth Singleton Corp. (48.13%) (MA)
Fourth Copley Corp. (48.13%) (MA)
Fourth Income Corp. (48.13%) (MA)
Fourth Singleton Corp. (48.13%) (MA)
Grand Cathay Securities Investment Trust Co., LTD (20%) (Taiwan)
General American Argentina Seguros De Vida, S.A. (57.9%) (Argentina)
Genesis Seguros Generales, Sociedad Anonima De Seguros Y Reaseguros (50%) (Spain)
Great Rivers Reinsurance Management, Inc. (48.13%) (MO)
Harris Associates, Inc. (48.13%) (DE)
Harris Associates, L.P. (48.13%) (DE)
Harris Associates Securities, L.P. (48.13%) (DE)
Harris Partners, Inc. (48.13%) (DE)
Harris Partners L.L.C. (48.13%) (DE)
Jurika & Voyles, Inc. (48.13%) (DE)
Jurika & Voyles, L.P. (48.13%) (DE)
Kobrick Funds LLC (48.13%) (DE)
Loomis, Sayles & Company, Inc. (48.13%) (MA)
Loomis, Sayles & Company, L.P. (48.13%) (DE)
Loomis, Sayles Distributors, Inc. (48.13%) (MA)
Loomis, Sayles Distributors, L.P. (48.13%) (DE)
Loomis, Sayles (Euro) Limited (48.13%) (United Kingdom)
Loomis Sayles (Australia) Holdings, LLC (Australia)
Loomis Sayles (Australia) Pty Limited (Australia)
Malaysia Life Reinsurance Group Berhad (17.37%) (Malaysia)

CORPORATE DISCLOSURE STATEMENT
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MC Management, Inc. (48.13%) (MA)
MC Management, L.P. (48.13%) (DE)
Mercadian Capital L.P. (95%) (DE)
Mercadian Funding L.P. (95%) (DE)
Metric Colorado, Inc. (80%) (CO)
Metropolitan Lloyds Insurance Company of Texas[2] (TX)
Metropolitan Structures (50%) (IL)
NEF Corporation (48.13%) (MA)
New England Funds, L.P. (48.13%) (DE)
New England Funds Management, L.P. (48.13%) (DE)
Nvest, L.P. (7.29%) (DE)
Nvest Associates, Inc. (48.13%) (DE)
Nvest Companies, L.P. (48.13%) (DE)
Nvest Holdings, Inc. (48.13%) (MA)
Nvest Partnerships, LLC (48.13%) (DE)
Persues Partners L.P. (0.005%) (DE)
Pleiades Partners L.P. (0.005%) (DE)
P.T. MetLife Sejahters (62%) (Indonesia)
R&T Asset Management, Inc. (48.13%) (MA)
Regal Atlantic Company (Bermuda) Ltd. (57.9%) (Bermuda)
Reich & Tang Asset Management, L.P. (48.13%) (DE)
Reich & Tang Distributors, Inc. (48.13%) (DE)
Reich & Tang Services, Inc. (48.13%) (DE)
Reinsurance Company of Missouri, Incorporated (57.9%) (MO)
Reinsurance Group of America, Incorporated (57.9%) (MO)
Reinsurance Partners, Inc. (57.9%) (MO)

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[2] Affilate

CORPORATE DISCLOSURE STATEMENT
– Continued

RGA Americas Reinsurance Company, Ltd. (57.9%) (Barbados)
RGA Argentina, S.A. (57.9%) (Argentina)
RGA Australian Holdings Pty Limited (57.9%) (Australia)
RGA Canada Management Company, Ltd. (57.9%) (Canada)
RGA Capital Limited (57.9%) (United Kingdom)
RGA Financial Group, L.L.C. (35.04%) (DE)
RGA Financial Products Limited (57.9%) (Canada)
RGA Life Reinsurance Company of Canada (57.9%) (Canada)
RGA Managing Agency Limited (57.9%) (United Kingdom)
RGA Reinsurance Company (57.9%) (MO)
RGA Reinsurance Company (Barbados) Ltd. (57.9%) (Barbados)
RGA Reinsurance Company of Australia Limited (57.9%) (Australia)
RGA Reinsurance Company of South Africa Limited (57.9%) (South Africa)
RGA Reinsurance (UK) Limited (57.9%) (United Kingdom)
RGA South African Holdings (Pty) Ltd. (57.9%) (South Africa)
RGA (U.K.) Underwriting Agency Limited (57.9%) (United Kingdom)
Santander Met, S.A. (50%) (Spain)
Second Income Corp. (48.13%) (MA)
Seguros Genesis, S.A. (Spain) (50%) (Spain)
Seventh Copley Corp. (48.13%) (MA)
Sixth Copley Corp. (48.13%) (MA)
Sixth Singleton Corp. (48.13%) (MA)
Snyder Capital Management, Inc. (48.13%) (DE)

CORPORATE DISCLOSURE STATEMENT
– Continued

Snyder Capital Management, L.P. (48.13%) (DE)
SPA Partners L.P. (0.005%) (DE)
St. James Fleet Investments Two Limited (34%) (Cayman Islands)
State Street Research Strategic Portfolios: Aggressive[3] (63.9%) (MA)
State Street Research Strategic Income Plus (71.9%) (MA)
State Street Research Intelliquant Portfolios: Small Cap Value (99.2%) (MA)
Stellar Partners L.P. (0.005%) (DE)
Texas American Horizon Services Agency, Inc. (57.2%) (TX)
Third Income Corporation (48.13%) (MA)
Third Singleton Corporation (48.13%) (MA)
Triad Re, Ltd. (32.36%) (Barbados)
Vaughan, Nelson, Scarborough & McCullough (48.13%) (DE)
Vaughan, Nelson, Scarborough & McCullough, L.P. (48.13%) (DE)
VNSM Trust Company (48.13%) (TX)
Westpeak Investment Advisors, Inc. (48.13%) (MA)
Westpeak Investment Advisors, L.P. (48.13%) (DE)
Westpeak Investment Advisors Australia Limited Pty. (48.13%) (Australia)

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[3] Mutual Fund

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OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondents METROPOLITAN LIFE INSURANCE COMPANY (hereinafter "MetLife") and JACK WICKWARE, ESQ., respectfully request that this Court deny the Petition for Writ of Certiorari seeking review of the Ninth Circuit's opinion in this case. That opinion is reported at 208 F.3d 1073 (9th Cir. 2000).

STATEMENT OF FACTS

In the action below, Petitioner STEVEN SIMON (hereinafter "Simon") sought to assert claims for ERISA[4] plan benefits under the guise of antitrust and RICO[5] conspiracy claims.

Simon was an officer of several mental health care organizations, Humanistic Mental Foundation, Seeds of Life, Inc., a California Corporation, HolistiCare, a California Corporation and Sunstar Healthcare, a California Corporation.

Simon filed his original complaint on June 27, 1996. Simon did not serve any of the defendants with that complaint.

On October 24, 1996, Simon filed his first amended complaint ("FAC"). In the FAC, Simon attempted to

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[4] The Retirement Income Security Act of 1974 as amended [29 U.S.C. § 1001, *et seq.*] ("ERISA").

[5] The Racketeering Influenced And Corrupt Organizations Act [18 U.S.C. § 1961, *et seq.*] ("RICO").

allege the following claims: (1) violations of the Sherman Anti-Trust Act; (2) violations of the Clayton Anti-Trust Act; (3) recovery of plan benefits under ERISA; (4) recovery of plan benefits under FEHBA [the Federal Employee Health Benefit Act, 5 U.S.C. § 8901, *et seq.*]; (5) violations of RICO; (6) tortious interference with contractual relations; and (7) tortious interference with prospective economic relations.

MetLife is informed and believes that Simon served his FAC on well over 100 defendants. Simon also filed various motions and ex parte applications to extend the time for him to serve his FAC on unserved defendants. Such motions and applications were denied by the District Court.

In response to Simon's FAC, many of the served defendants filed and joined in numerous motions to dismiss, motions to quash, motions for more definite statements, and motions to strike. All of the defendants' motions attacking Simon's FAC were granted in whole or in part. Although the District Court made many specific rulings on defendants' various motions, the end result was that Simon's FAC was dismissed on February 27, 1997 and he was granted leave to file his second amended complaint ("SAC") on or before May 1, 1997.

Simon subsequently filed ex parte applications and motions for clarification, amendment, and reconsideration of the District Court's Orders concerning defendants' motions. All of Simon's applications and motions were denied by the District Court.

On May 1, 1997, Simon filed his SAC. Simon's SAC purports to allege the following claims: (1) violations of

the Sherman Anti-Trust Act; (2) violations of the Clayton Anti-Trust Act; (3) violations of RICO; and (4) recovery of plan benefits under FEHBA.

On May 9, 1997 Simon filed a motion to amend his SAC which was opposed by numerous defendants. The District Court granted Simon's motion in part and denied it in part.

Following its receipt of Simon's SAC, the District Court scheduled a status conference with Simon for July 7, 1997 to discuss the obvious deficiencies in his pleading and the nature of Simon's claims as well as the practicality and logistics of the action. Following the status conference and after addressing specific concerns with Simon, the District Court, among other things, dismissed without prejudice all of the defendants from the action except the first named defendant, Value Behavioral Health, Inc., and ordered Simon to file his Third Amended Complaint ("TAC") within 30 days stating clearly any claims he may have against that single defendant.

Simon subsequently filed his TAC against defendant Value Behavioral Health. Defendant Value Bahavioral Health filed a motion to dismiss Simon's TAC. Simon also filed a motion to stay the proceedings and a motion to amend the TAC and join additional parties. On March 2, 1998, the District Court denied Simon's motion to stay the proceedings and motion to amend the complaint and join additional parties, and granted defendant Value Behavioral Health's motion to dismiss the TAC with prejudice.

On April 30, 1998, Simon filed his Notice of Appeals with the Court of Appeals for the Ninth Circuit. Simon's

appeal addressed, among other things, all of the rulings and orders referenced above.

On June 7, 2000, the Court of Appeals for the Ninth Circuit affirmed the District Court's decision. The Ninth Circuit's decision specified that under ERISA, federal anti-trust law and RICO, Simon as the assignee of health care providers, who are themselves assignees of patient's benefits claims, lacks standing to sue insurers and related entities to recover on those claims. Moreover, Simon lacked standing because he was neither a plan participant nor a beneficiary of a health benefit plan within the meaning of ERISA, and was ineligible for derivative standing as a health care provider.

Simon has petitioned this Court for a writ of certiorari which was placed on the Court's docket on November 20, 2000.

REASONS WHY THE PETITION SHOULD BE DENIED

1. Neither the Decision Below nor the Record Raises Considerations of Fact and Law Sufficient to Establish Grounds for Granting Certiorari.

"Review on a writ of certiorari is not a matter of right, but of judicial discretion."[6]

Rules of the Supreme Court, Rule 10, unambiguously provides that "[a] petition for a writ of certiorari will be granted only for compelling reasons."[7] Thus, the petition

[6] Sup. Ct. R. 10 (2000).

[7] *Id.*

should present questions involving principles of great public importance[8] or those that require resolution of conflicts of authority.[9] Where the purported error asserted by a petition consists simply of erroneous factual findings or the misapplication of a properly stated rule of law,[10] review is not warranted.

This petition presents no basis for review of certiorari. Petitioner simply levels undifferentiated claims

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[8] See *Nat'l Labor Relations Bd. v. Pittsburgh S.S. Co.*, 340 U.S. 498 (1951).

[9] See *Daniel v. Family Security Life Ins. Co.*, 336 U.S. 220 (1949); *Sonzinsky v. U.S.*, 300 U.S. 506 (1937). Specifically, Rule 10 sets forth three categories which "indicate the character of the reasons the Court considers:"

> (a) a United States court of appeals has entered a decision in conflict with the decision of another United States court of appeals on the same important matter; has decided an important federal question in a way that conflicts with a decision by a state court of last resort; or has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of this Court's supervisory power;
>
> (b) a state court of last resort has decided an important federal question in a way that conflicts with the decision of another state court of last resort or of a United States court of appeals;
>
> (c) a state court or a United States court of appeals has decided an important question of federal law that has not been, but should be, settled by this Court, or has decided an important federal question in a way that conflicts with relevant decisions of this Court.

[10] Sup. Ct. R. 10 (2000).

that he has been "wronged" by the "system." While Petitioner may have personal reasons for pursuing this litigation, he lacks a cognizable legal claim upon which to couch his grievances. To date, Petitioner has been defeated in each of the court battles he has waged. Not to be dissuaded by these defeats, Petitioner nevertheless remains committed to his "cause" and now petitions this Court in a final effort to achieve victory. However, when considered against the framework of Rule 10, the petition presents no basis for review.

2. Certiorari Should be Denied Because This Case Presents no Questions Which Have Relevance or Importance Beyond the Particular Facts and Parties Involved.

Certiorari should be denied because the issues raised by Simon turn solely upon an analysis of the particular facts involved herein and upon construction of particular contracts.

Specifically, Simon contends that certain claims for health benefits submitted by his assignor providers to ERISA employee benefit plans were improperly denied because of the limits on such benefits payable for treatment of psychiatric/mental/emotional disorders. Simon contends such limitations are invalid because the plans provided for the payment of higher benefits for the treatment of physical disorders. Simon also asserts federal antitrust and RICO violations premised upon his objection to the limitations on the amount of benefits payable under the Plans for mental health care, and the use of preferred provider networks. However, after distilling

the redundant and immaterial statements in the complaints, it is evident that Simon's action is merely an improperly joined "mass-collection" action against employee benefit plans and insurers for unpaid medical bills.

With respect to MetLife, Simon is attempting to assert claims for health benefits allegedly due under the Empire Plan.

The Empire Plan was established and is maintained by New York State for the benefit of its employees, and is therefore a "governmental plan" exempt from the ERISA, 29 U.S.C. §§ 1001-1461.[11] As such, contrary to Simon's contention, the Empire Plan is *not* an "ERISA plan" and MetLife's administration of that plan gives rise to no cognizable claim under the federal statutory scheme.[12] Further, the Empire Plan requires that payment for covered medical services be made only to enrollees or participating providers and expressly prohibits enrollees from assigning their right of payment to non-participating providers. Specifically, the Empire Plan does not permit assignment of benefits to a non-participating provider. As

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[11] *See* 29 U.S.C. § 1002(32) and 1003(b)(1).

[12] Petitioner classifies all the plans as ERISA plans and poses the following question: "(b) why did Judge Taylor quash Petitioner's service of process upon hundreds of ERISA plans without apparent regard to the ERISA statute or proper review of the ERISA plan documents and despite Petitioner's opposition(s)?" See Petition at p. 4.

a purported assignee of rights that do not exist under the Empire Plan, Simon lacks Standing.[13]

In addition, with respect to all claims at issue, the statute of limitations ran two years and 90 days after the end of the calendar year in which the claim(s) accrued.[14] All of Simon's alleged claims against MetLife are time-barred since the claims accrued as early as 1979 through March 1993.

Simon is improperly bringing the action as an assignee of an assignee. The original assignor of the claims for benefits consist of more than 638 individual patients who are participants and/or beneficiaries of named employee benefit plans. These claims for benefits were eventually assigned to Simon.

This case requires analysis of the evidence and discussions of specific facts relevant to each defendant. Moreover, it does not present issues beyond the parochial concerns of the petitioner. Accordingly, review should not be granted.

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[13] *Home Intensive Care, Inc. v. Metropolitan Life Ins. Co.*, N.Y.L.J. (July 30, 1993) at 23, col. 3 (Sup. Ct. N.Y. Co. 1993).

[14] *Rodriguez v. Nationwide Ins. Co.*, 97 A.D.2d 817, 468 N.Y.S.2d 693 (2d Dept. 1983) and N.Y. Ins. Law § 3221(a)(14) (1997).

CONCLUSION

For these reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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Jack Wickware, Esq.

FILED
DEC 20 2000
CLERK

No. 00-801

IN THE

Supreme Court of the United States

STEPHEN SIMON,

Petitioner,

v.

VALUE BEHAVIORAL HEALTH INC., *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF CERTAIN RESPONDENTS IN OPPOSITION

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Attorneys for Respondents

(Additional Counsel and the names of the Certain Respondents are listed on the signature page)

164216

Counsel Press LLC
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CORPORATE DISCLOSURE STATEMENT

The following Respondents have no parent corporations and no publicly held company owns 10% or more of any of its stock: The Prudential Insurance Company of America, The Guardian Life Insurance Company of America, Pacific Mutual Life Insurance Company, PM Group Life Insurance Company, Blue Cross/Blue Shield of Ohio, Mutual Health Service Co., McDonough Caperton, Inc., McDonough Caperton, Inc. Employee Benefit Plan, Health Management Strategies International, Inc., Capp Care, Inc., Benefit Panel Services, PCA, Health International, PPG Industries, Inc., Rocky Mountain Medical Service, dba Blue Cross and Blue Shield of Colorado and Stanislaus Foundation for Medical Care.

Respondent, The Great-West Life Assurance Company, is the subsidiary of Great West Life Co., Inc., whose parent companies are Power Financial Corporation and Power Corporation of Canada. Power Corporation of Canada is a publicly held company in Canada.

Respondent ReliaStar Life Insurance Company is a subsidiary of ING Groep N.V. which is publicly traded and owns more than 10% of the stock of ReliaStar Life Insurance Company.

The parent company for Respondents, Value Behavioral Health, Inc., Value Health, Inc., Preferred HealthCare, Ltd., and American Psychmanagement, Inc., is Value Options, Inc., which is wholly owned by FHC Health Systems, Inc. No publicly held company owns 10% or more of the stock of these Respondents.

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THE CASE BELOW

A. *Petitioner's Claims Below.*

Petitioner brought an action in the United States District Court For the Central District of California in which he joined (i) approximately 600 separate, unrelated ERISA[1] plan benefit claims, (ii) antitrust claims under the Clayton Act and the Sherman Act, (iii) RICO[2] claims, and (iv) certain state law tort claims.

The claims were asserted against approximately 1,600 defendants, consisting of companies and their ERISA plans, individual chief executive and other officers, the insurance companies which funded certain of the ERISA plans, and a number of their chief executive and other officers, together with governmental entities and agencies.

B. *The Service Of Process Problems.*

Petitioner attempted to serve all of the ERISA plans by serving insurance companies which were not the plan administrator or plan trustee, as required by 29 U.S.C. § 1132(d)(1). The District Court gave petitioner three months of additional time to effect service, but set a time limit by which petitioner had to accomplish service and held to it. This was ample time for petitioner to have served the plans, or the Secretary of Labor on behalf of the plans, under 29 U.S.C. § 1132(d)(1).

---

1. The Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1001, *et seq.*] ("ERISA").

2. The Racketeering Influenced And Corrupt Organizations Act [18 U.S.C. § 1961, *et seq.*] ("RICO").

C. ***The Dismissal Of Petitioner's Various Claims.***

1. Petitioner's ERISA claims were dismissed on the ground that, as the assignee of assignee medical providers, he was not a person authorized to sue for plan benefits under ERISA. Petitioner was specifically given leave to refile these claims separately.

2. Petitioner's state law claims were dismissed or abandoned as being preempted by ERISA, which applied whether or not he had standing.

3. Petitioner's Clayton Act claims were dismissed on the grounds that the Clayton Act does not apply to services, and petitioner was suing to recover for services allegedly rendered by his assignor providers.

4. Petitioner's Sherman Act claims were ultimately dismissed without leave on the grounds that petitioner failed to allege, after repeated tries and pointed suggestions from the District Court, (i) a contract, combination or conspiracy among two or more distinct business entities not under common ownership, (ii) which was intended to harm or unreasonably restrain competition in interstate commerce, (iii) which actually caused injury to such competition, and (iv) that such injury was in the identified, defined product and geographic market in which petitioner's assignor providers engaged in commerce.

5. Petitioner alleged that his assignors had been injured by the coming into existence of preferred provider networks (which he claimed to be one giant entity), managed care organizations, and two-tiered contracts, which pay a higher percentage of provider fees to those providers who are in the particular plan's list of preferred providers, than to out-of-network providers. Petitioner's basic failure, as repeatedly

pointed out to him by the District Judge, was a complete failure to allege facts to show any concerted action among the defendants.

6. Petitioner's RICO claims were ultimately dismissed without leave on the grounds that petitioner failed to allege, after repeated tries and further suggestions from the District Court, (i) a RICO enterprise that was separate and distinct from the alleged pattern of racketeering activity, (ii) that the various defendants participated as principals in the pattern of racketeering activity, received income from that activity, and directly or indirectly invested the income in an enterprise which affected interstate commerce, and (iii) participation in a conspiracy to engage in a pattern of racketeering activity.

D. ***The District Court's Procedural Orders And Conduct.***

The District Court at no time chastised petitioner for bringing his action. The Court expressed concern over how the case was going to proceed, and whether it would ever be at issue. The Court told petitioner repeatedly that he needed to make short, plain statements of fact in his complaints to set forth his claims, and that he needed to state facts to show some concerted action among any defendants against whom he wished to state conspiracy claims. The thrust of the Court's suggestions was that it was not enough to allege that the United States Marines and Proctor & Gamble both used managed care programs, with preferred providers and two-tiered provider reimbursement, therefore they had conspired against petitioner's assignor providers.

Petitioner initiated discovery before he had a complaint on file which stated a viable claim. Petitioner planned to conduct depositions all around the country, initially of the

chief executive and other senior officers of defendant companies, and required massive document productions, as to which petitioner suggested that a large document repository be established.

The District Court declined to allow that process to go forward, with the enormous expense involved, until petitioner had demonstrated that he could state a claim against at least one defendant. In this connection, the Court made a case management order dismissing, without prejudice, and subject to being rejoined if the facts supported it, all defendants except Value Behavioral Health, Inc. Petitioner was instructed to set forth a short plain statement of his claims, to see if he could state a viable claim against one defendant, with the proviso that others could be joined on motion if facts were alleged to justify joinder.

THE OPINIONS BELOW

There are two published opinions in this case, one by the District Court, *Stephen Simon v. Value Behavioral Health Inc., et al.*, 955 F. Supp. 973 (C.D. Cal. 1997), dismissing petitioner's ERISA claims, and the other an affirmance by the Ninth Circuit, after more pleadings and the ultimate dismissal of the action without leave, *Stephen Simon v. Value Behavioral Health Inc., et al.*, 208 F.3d 1072 (9th Cir. 2000). Copies are appended to the petition.

REASONS FOR DENYING THE WRIT

The petitioner's argumentative "questions presented" fail to set forth any basis for granting a writ of certiorari.

A. *Petitioner Has Set Forth No Basis For The Exercise Of Certiorari Jurisdiction. He Is Merely Seeking A Further Hearing On The Basis Of Alleged Error.*

The questions presented by petitioner appear to be (i) error below in finding he had no standing to bring assigned ERISA benefit claims, (ii) error below in dismissing petitioner's antitrust claims, (iii) error below in not further extending time to petitioner for the service of process, (iv) error below in not giving petitioner, as a *pro se* litigant, even more latitude, and (v) error by the Ninth Circuit in not reversing the District Court.

None of these matters are supported in the petition, and if they were, these questions show only that petitioner is seeking a further hearing after defeat in the Ninth Circuit. None of the reasons set forth in Rule 10 of the Supreme Court Rules, nor any reasons of similar character, are set forth in the petition. No showing has been made of any conflict in the circuits, decision on an important federal question in conflict with a decision of a state court of last resort, or departure from accepted judicial procedure sufficient to require supervision by this Court, as to the proceedings below.

No important issues of federal law and no Constitutional issues have been raised in the petition.

B. *The District Court And The Ninth Circuit Properly Applied Statutory Provisions And Well-Established Case Law.*

The District Court and the Ninth Circuit properly determined that petitioner, as the assignee of providers who were in turn assignees of the plan participants or

beneficiaries, was not a person authorized to sue for benefits by 29 U.S.C. § 1132(a)(1)(B). That section limits the persons authorized to bring a civil action to recover benefits to plan participants and beneficiaries. Petitioner was neither.

Petitioner's antitrust and RICO claims were properly denied because he failed to allege facts sufficient to constitute a claim. The District and Circuit Courts merely applied well-established precedent.

C. *Petitioner's Claims Of Mistreatment, Evidence Suppression And Misconduct By Both The District Court And The Ninth Circuit Are Untrue.*

All of petitioner's claims of mistreatment and misconduct by the District Court and the Ninth Circuit amount to no more than that those Courts did not agree with him.

Petitioner has claimed, among other things, that he was not accorded proper latitude as a *pro se* litigant, and that the District Court mistreated him by being impatient with petitioner and refusing "to allow adequate time" to serve the approximately 1,600 defendants, staying discovery (referred to as "suppression of evidence"), and not accepting petitioner's allegations as true.

In fact, the District Court displayed great forbearance and courtesy in dealing with petitioner, and allowed him ninety additional days for service of process. The District Court stayed discovery as premature until a proper complaint was filed because of the prospect of enormous expense involved. The District Court did accept petitioner's factual allegations as true, but found them insufficient to state a claim.

Petitioner has not supported any of his allegations against the courts by any facts or authority in his petition.

Petitioner's Second Amended Complaint was 182 pages long, of which the first 39 pages were caption to name the defendants. To this was appended an Exhibit 1 of 323 pages, plus additional documents as Exhibits A through V. In none of that expanse did he manage to plead facts constituting a claim.

This was typical of petitioner's pleadings, which all consisted of lengthy narrative and argument and never alleged facts to establish the necessary elements of his antitrust and RICO claims.

Petitioner had four attempts to state his purported claims. The District Court, in its order dated August 14, 1997, instructed petitioner to make a short, plain statement of his claims against the remaining defendant, Value Behavioral. Petitioner ignored that order and filed a lengthy, rambling pleading which purported to incorporate all of his prior pleadings not ordered stricken and which realleged essentially the same narratives and theories pleaded in the first and second amended complaints. That alone justified dismissal under Rule 8 and Rule 41(b) of the Federal Rules of Civil Procedure [*McHenry v. Renne*, 84 F.3d 1172, 1177-1179 (9th Cir. 1996)].

Petitioner's claims all required acceptance of his generalized, conclusionary allegations of an industry-wide conspiracy against his assignor providers. His problem throughout was that which the District Court expressed with respect to petitioner's second amended complaint, in its order of August 14, 1997:

> It has become apparent to the Court that the only factual connection between the numerous defendants is their participation in the diverse field of health care . . . Plaintiff's Second Amended Complaint fails to allege any facts which reflect all of the nearly 1600 defendants have engaged in a common course of conduct sufficient to support Plaintiff's Sherman Act, Clayton Act, RICO or FEHB claims.

All of petitioner's Sherman Act, Clayton Act, RICO and FEHB violations were founded on the existence of this conspiracy. The formation of "Preferred Providers," the coming into existence of HMO's and managed care were all attributed to the conspiracy, and alleged to be fraudulent, without supporting specifics.

How all of this came into being as a result of concerted action was never alleged. No role of any defendant in creating any of these matters was ever alleged. This Court may take judicial notice of the common knowledge that preferred provider organizations and managed care developed over time beginning in the 1950's, with the Blue Cross-Blue Shield hospital and physician networks, Kaiser Permanente, Ross-Loos, and similar organizations, and were cost driven from the start.

All of petitioner's claims failed because of his failure to allege facts to support his conspiracy theory, apart from all of the other deficiencies in his pleadings. Managed care, HMO's and preferred provider networks came into existence to contain cost. Petitioner does not like the results, which apparently prevented his assignor providers from continuing to charge fees at the level to which they had become

accustomed. That did not entitle petitioner to antitrust and RICO relief.

The District Court properly dismissed his action with prejudice, and the Ninth Circuit properly affirmed.

CONCLUSION

Petitioner has presented no questions which warrant review by this Court, and has not supported the questions he has stated.

It is therefore respectfully submitted that petitioner's Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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